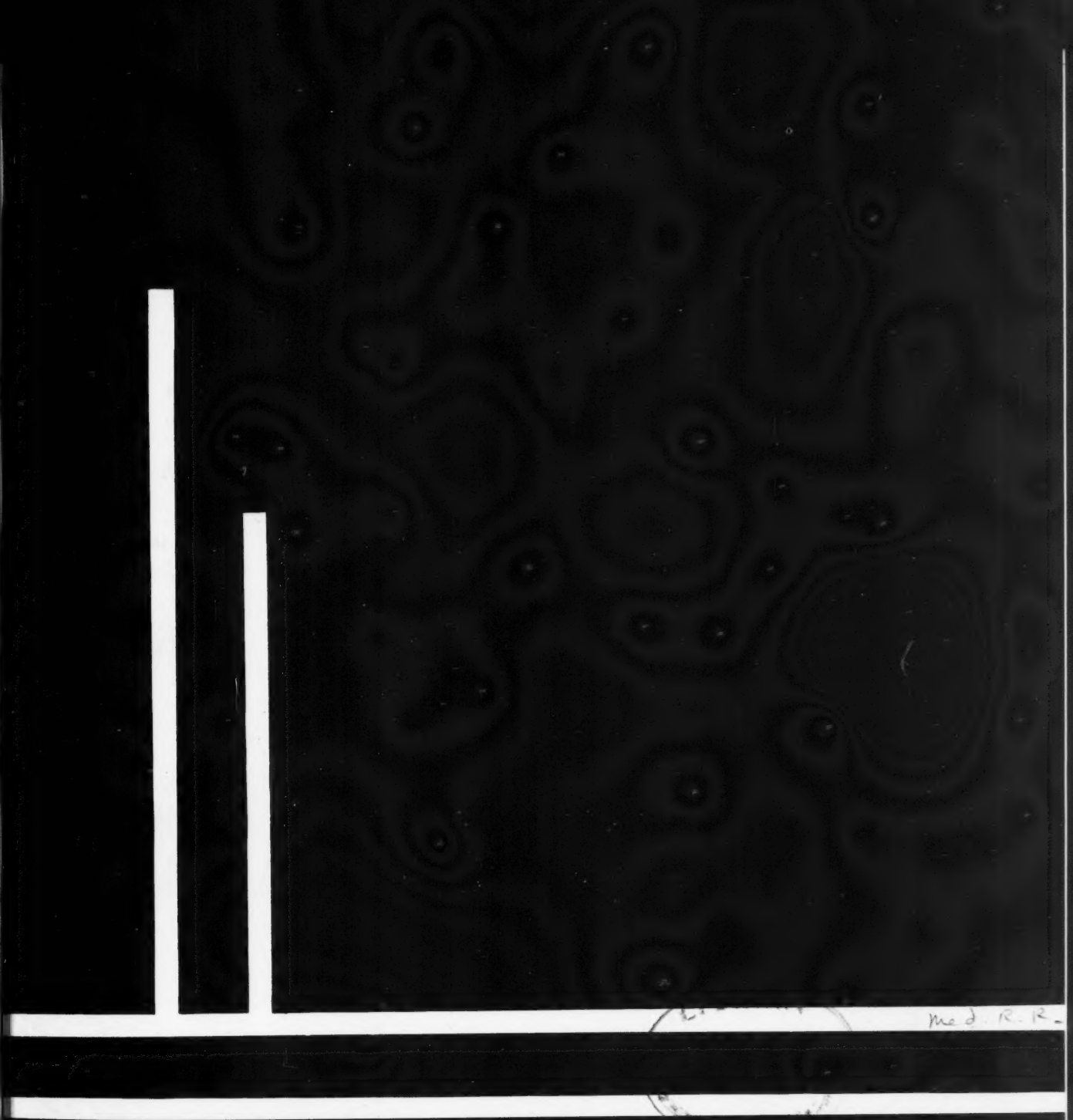


TORONTO, DECEMBER, 1942

THE CANADIAN HOSPITAL

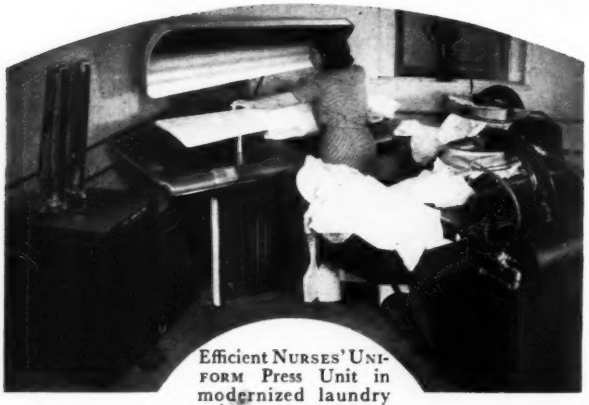
· OFFICIAL JOURNAL · CANADIAN HOSPITAL COUNCIL ·

American 4-Roll STREAMLINE Flatwork Ironer which produces a plentiful supply of beautifully ironed linens to meet the added demands of Mercy Hospital's new 100-bed annex.

Since

MERCY HOSPITAL MODERNIZED *its* LAUNDRY DEPARTMENT

the laundry operates two hours less each day



Efficient NURSES' UNIFORM Press Unit in modernized laundry department at Mercy Hospital, Toledo, O.

When Mercy Hospital, Toledo, O., decided to build a 100-bed annex, the laundry department was already overtaxed. It was apparent that capacity of the laundry would have to be increased.

An American Laundry Adviser was called in to make a careful survey. Based on his recommendations, the modern, more productive equipment shown on this page was installed.

The NURSES' UNIFORM Unit made it possible to beautifully iron three to four times as many garments an hour as on the former presses . . . and with only one hand finisher instead of four previously used. The three hand finishers from the press unit were transferred to the ironer crew, to keep pace with the increased production of the new 4-Roll STREAMLINE Flatwork Ironer.

Ask for a Canadian Laundry Adviser

Now, Mercy Hospital's laundry has the increased capacity to more than handle all the additional work from the 100-bed annex under construction . . . in exactly the same space, and with no more help. Even more remarkable, the laundry is *operating two hours less each day.*

Have you a laundering problem? If so, we invite you to take advantage of our helpful Laundry Advisory Service . . . offered to hospitals of every size, absolutely without cost or obligation. Write us . . . today.

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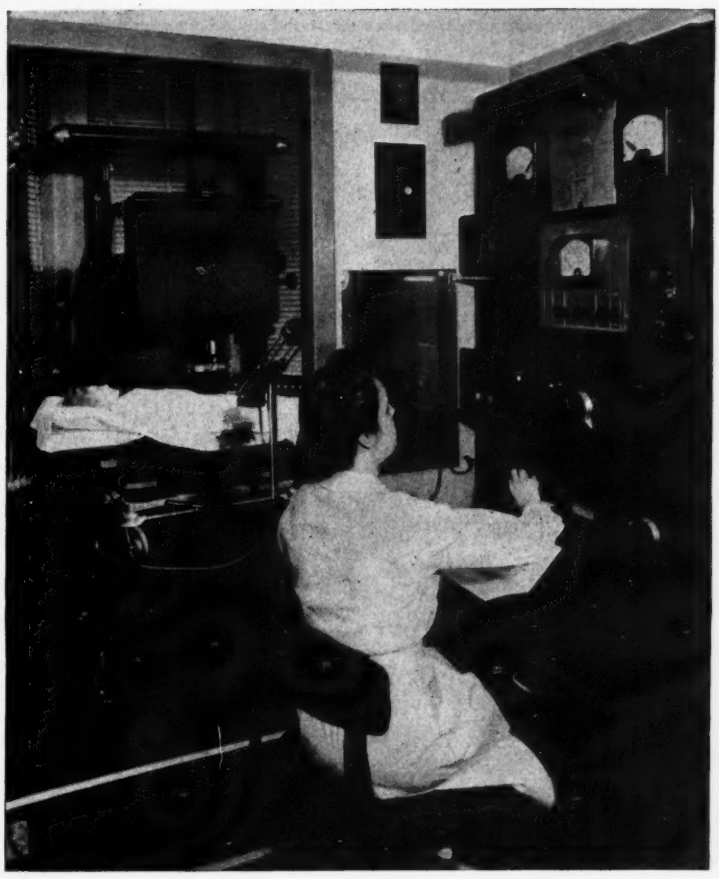

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"The Canadian Hospital"

Official Journal of the
Canadian Hospital Council

DECEMBER, 1942

CONTENTS

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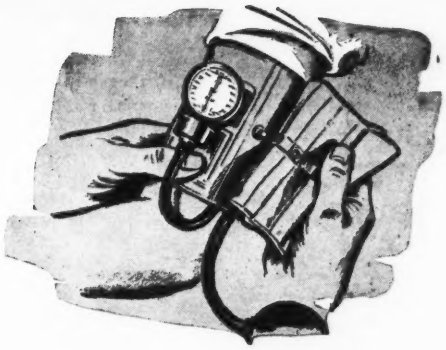

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☆ *The details above are of an actual case. The illustration is made from photographs taken of this case. In the belief that such authentic records may be of general interest, the manufacturers of 'Elastoplast' are publishing these instances typical of the many in which their products have been used with outstanding success.*

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(1) 1939, Food and Life: Yearbook of Agriculture
U. S. Dept. Agriculture, U. S. Gov't
Printing Office, Washington, D. C.

Harvey Agnew, M.D., *Editor*

The CANADIAN HOSPITAL

Toronto, December, 1942 Vol. 19 No. 12

A Continuous Drama in Ten Acts

The Hospital in War

By MALCOLM T. MacEACHERN, M.D., C.M.
D.Sc., L.L.D., F.A.C.H.A.,
Associate Director, American College of Surgeons

THE hospital in war shares with every other institution in our complicated civilization a disturbance of its normal functioning. It experiences more demand for its services at the same time that the supplies by means of which and the personnel through whom they are rendered, are severely restricted. I doubt whether there is any significant difference between the situation in which hospitals in Canada find themselves to-day and that which prevails in the United States, except that Canada having been in the war longer, her hospitals have had more experience in adversity. Their personnel are not crying out quite so loudly as are those who have more recently begun to feel the pressure of war limitations. They are taking more for granted the necessity of sacrificing personal inclinations for strenuous war duty, whether on the military or on the civilian front, and have begun to acquire the stoicism to hardship that the people of the United States must cultivate.

Luncheon Address at the Wartime Conference of the Ontario Hospital Association and Allied Associations, Toronto, October 1942.

I was interested in an editorial along these lines that recently appeared on the front page of Panamanian newspaper. In effect it said that this generation has had so easy a life that it has not created a temperament for suffering. It is not of the same calibre as the generations that discovered and explored and pioneered America. It is easily aroused to resentment if its pleasant routine is threatened, and its spirit flags when the least obstacle appears. The editorial writer counseled that since our small sacrifices of to-day will be, without doubt, a little thing in relation to those we might have to bear to-morrow, we should prepare ourselves to suffer—steel ourselves to uncomplaining determination to conquer all obstacles.

We now see signs of the budding of such a spirit. Heretofore there has been a demand by our hospital people that somebody solve their various problems. This time the fact is being faced that few of these problems can really be solved, that nobody else can furnish an easy answer. We now realize that they must be attacked and solved—to the extent to which they can be solved—by each hospital devising ways to overcome its own peculiar difficulties. A zest for the battle against obstacles has been apparent at recent conventions, a new spirit of relish for showing what we can do, despite the drain on our resources to fight the Nazis and the Japs. Fear and fainthearted-ness depart as the shadows of war deepen around us, and as we grow accustomed to trying to accomplish more, with less and less with which to work.

A defeatist attitude is as disastrous for hospitals in the present crisis as it is for nations. Long and hard though the struggle may be, we know that we shall win this war. Moreover, recognizing as we do the difficulties besetting hospitals, we are sure that we shall overcome them by accepting them as a challenge to supreme effort.

Dependence on Hospitals

There can be no doubt that in time of war more dependence is placed upon the hospital than in peace. A heightened consciousness arises on the part of the government

The hospital in the war is the symbol of the very spirit of democracy, the scene of ministry to the suffering of any class, creed, race or condition of life. We are proud, every one of us, to be actors in the drama of hospital work—to try to play well our parts of alleviating misery and helping to bring about a happier world.

and the public that health is a national asset and that hospitals are vital to its conservation. There are visions of bombs falling from the skies, and of resulting casualties for the care of which there must be hospitals and trained personnel. The people are in a more appreciative mood towards the hospital than in normal times. Their forbearance towards the necessary streamlining of certain services can easily be won by explanations, not in a complaining vein of course, of the difficulties that beset hospitals. Good will can be cultivated and carried over from this war era, if hospitals present a good war performance.

A Hospital Drama

The drama that hospitals are staging during the war has at least ten acts which we may briefly consider against their background of wartime turbulence, restrictions and suffering.

The curtain goes up on a view of the hospital in its normal role of caring for mothers and infants, the sick and the injured, work which must go on, war or no war.

Act I. The Hospital in its Regular Line of Duty

About 7,500 hospitals in Canada and the United States, having a total of nearly a million and a half beds and bassinets, serve a population of almost 150,000,000 people. Therefore we have a ratio of hospital beds to population of about one to every one hundred. Last year eight out of each hundred persons in Canada and twelve out of each hundred in the United States were inpatients in hospitals. In addition thousands of persons received outpatient service. Births in hospitals in the United States and Canada totalled more than one and a half million last year—more than half of the total births in the United States and almost half of those in Canada.

The war will in no way lessen the regular work of hospitals. The six or seven million men and women who have entered the armed services present no appreciable reduction of responsibility, because they are the portion of our population least liable to require hospitalization under normal circumstances.

The demand for civilian hospitalization is, in fact, rising. Drastic measures have had to be taken in some places to enable hospitals to meet the increased demands for and practically all hospitals are being forced to simplify and standardize service, to conserve the time of overburdened personnel.

Act I of this drama is an exciting one. We see increasing numbers of patients streaming into hospitals, and watch the reduced staffs of doctors, nurses and other personnel striving to take care of them properly. We see private rooms made into two or four-bed wards, and nurses' homes and lounges converted into hospital quarters, to provide space for the added patients. In some communities we even see nearby hotels and large residences being used to supplement the regular hospital facilities.

The drama of hospitals in war differs from ordinary plays—the curtain never goes down between the acts.

Act II. The Hospital and the Army of Production

Conserving the health of war workers and caring for their injuries are vitally important duties in wartime. The army of production is larger than in normal times, the hazards are greater, the work is more dangerous and the pace is faster. Fatigue from overtime lowers resistance to disease; new workers and workers too young or too old for the tasks assigned to them are naturally more prone to accidents than well-trained workers. The constant danger of sabotage threatens war industries. Last year's record of 101,500 dead, 350,000 permanently injured and 9,000,000 lesser casualties in industrial accidents in the United States is being exceeded about 12 per cent this year, according to a recent estimate. This means, inescapably, more work for hospitals.

Another difficulty confronting hospitals is the rapid shifts of workers to new industrial communities where there are far from adequate hospital facilities.

Since it is just as vital to winning the war to keep our industrial manpower fit as it is to guard the health of the military forces, it is very desirable that hospital personnel recognize the important role that they thus indirectly play in war production.

Act III. The Hospital in Time of Disaster

By this I mean the disaster that could occur in peacetime—flood, fire, earthquake, tornado, railroad wreck. The emergency department of a hospital must be so equipped and organized that it is always ready for any contingency. The difference in wartime is that the urgency is greater to relieve the situation quickly.

Act IV. The Hospital as the Centre of Civilian Defence

In both countries provisions for the defence of our home and industrial communities naturally centre in the hospital. It is in and through them that emergency medical units are best organized, and it is they who must make plans for rapid expansion of facilities and protection of patients in case of bombings or other enemy action. In the United States a plan has been formulated to designate certain hospitals and other appropriate institutions in areas least liable to trouble as emergency base hospitals for reception of casualties or other patients whom it may be necessary to evacuate from casualty receiving hospitals. Arrangements have been made for reimbursement of these hospitals by the Federal Government at established rates for hospital and medical care and, in addi-

Courtesy Toronto Western Hospital.

Silent Night! Holy Night!

tion, federally owned medical equipment may be loaned to them, and their medical staffs supplemented by physicians of the area who will be commissioned in the reserve corps of the U.S. Public Health Service.

The hospital that is well prepared for the more common kinds of disasters will have gone a long way towards being prepared for the disasters that may occur through war causes. In addition, of course, it must be prepared to function during blackouts, and must make provision for protecting patients in case of air raids.

Act V. The Hospital and its Personnel

In our previous scenes, we saw that the hospital was receiving more and more patients, besides having to prepare for the reception of large numbers in case of emergency. Now we see an exodus—see the doctors and nurses and technicians and other key personnel departing for war service. Non-professional personnel are leaving too, either for war service or attracted by the higher wages offered by war industries. Is there any way out of this dilemma of trying to serve more people with less help?

At the recent A.H.A. meeting, Paul V. McNutt, Chairman of the War Manpower Commission, recommended to hospitals that they copy industry's system of "upgrading" personnel. This, he explained, meant to plan for the best use of personnel—to utilize 100 per cent of the medical and nursing skill and training within our hospitals for 100 per cent medical needs, transferring non-medical work wherever possible to non-medical personnel, and using every trained man and woman at top skill every hour of his or her working day.

Other suggestions that he made were to curtail private duty nursing and other forms of luxury nursing, and to utilize volunteer aides to the fullest possible extent. This our hospitals are doing. They are also following the example of industry and employing more women. They are training new personnel. They are calling back their retired physicians and nurses to active duty. Above all, they are inspiring their personnel to regard their service as essential to winning the war. In the United States, as in Canada, there is talk of a badge identifying hospital personnel as being employed in essential civilian service. As your own magazine, THE CANADIAN HOSPITAL pointed out editorially a few issues back, "many individuals have chosen to remain in a vital position in a civilian hospital rather than to accept a more enticing position, perhaps with uniform and higher pay but with less prospect of using their special qualifications in the country's service." Identification through a button or badge might help other people to realize that their services are recognized by the government, and it might also help to maintain the morale of hospital people generally.

Act VI. The Hospital as a Consumer

In this act we have some very troublesome episodes: yet it is a patriotic duty to conserve and to salvage supplies and materials, to use substitutes for critical materials whenever possible and to use discretion in requesting permits and priorities. At the American Hospital Association meeting a resolution was passed urging all hospitals to dig out of their attics and basements all of the old equipment, furnishings and supplies that they could find to use before they asked for new material.

Simplification and standardization cut down the requirements for many items. As time goes on and shortages grow worse, undoubtedly a system of sharing equipment among hospitals will have to be developed.

Act VII. The Hospital as a Training Centre

Training personnel to the full extent of their capabilities is the best way open to us of compensating for the loss of skilled men and women to the armed forces. If it is not seriously undertaken in the case of every intern, resident, nurse, technician and other skilled or unskilled employee, there is bound to be retrogression in standards of hospital service that will be harmful to patients.

Vitally important war work is being done in hospitals in training personnel for military service. Intensified programmes for training doctors, nurses, technicians, dietitians, physiotherapists, anaesthetists and others, are being carried on, to assure well-trained medical corps personnel as well as competent service to civilians. Hospitals are co-operating with medical schools in the accelerated programmes and are increasing their nursing school enrolments.

The hospital is also an educational centre for the public. In it volunteer aides are being trained, first aid and home nursing courses are being given and lectures on the conservation of health are being or should be held.

Act VIII. The Hospital and the Rejected Applicant for Military Service

Analysis of the causes of rejection for military service should be made in every community, and in the cases of those whose defect could be remedied by surgery or other treatment in the hospital, the hospital should exhibit active interest. By prompt care many of these men can be salvaged for military duty, or at least be rehabilitated so that they will be more valuable in the battle of production.

Act IX. The Hospital as the Proving Ground for Medical Science

In wartime there is unavoidable reduction in the amount of scientific research carried on, because so many of those who have been engaged in it have gone into active military service and the remainder are overloaded with work. This is somewhat compensated for, however, by the development of new theories and procedures on the fighting front. Clinical research is therefore stimulated if

(Concluded on page 46)

A Technical Expert Talks to Trustees and Administrators.

Better X-ray Diagnosis in Small Hospitals

By P. E. HUNT, R.T., Saskatoon Sanatorium

THIS paper has been prepared not so much for the technician as for the executives, trustees, superintendents of nurses and purchasing agents of hospitals, and deals with the purchasing and installation of X-ray equipment and the selection of a suitable technician.

Equipment

It is not necessary to purchase an X-ray unit which has many complicated mechanical adjustments—devices for going up and coming down and turning round. Such a machine will not, of itself, give you the best radiographs you can get. Radiography, like medicine, is an art scientifically applied, and more depends upon the operator than upon the machine. The initial cost of equipment does not need to be excessive; perhaps the worst mistake you can make is to invest four or five thousand dollars in equipment—and then select an untrained operator. It is far better to spend much less money on equipment and obtain an operator who has been efficiently trained. Be assured that a well-trained technician would save more than the little extra salary you might have to pay, while at the same time giving you and your patients better service.

The number of beds in your hospital plus the daily average of outpatients may be used as a guide in determining the size of the X-ray unit which will best serve your requirements. (See Table).

There will be exceptions to this, of course, where there are special needs. The demand for X-ray services is increasing. With this in mind you should guard against underestimating the amount of work that the department will be called upon to do. Plan for additions that can be economically made as needed.

As accessories to the X-ray unit you should obtain a *timer,* which will permit measured exposures of less than one second. Such a timer is an absolute necessity, especially for X-ray films of the chest where the time of exposure is far too short to be correctly estimated by human senses.

You should acquire also a stationary *wafer-grid* of the Lysholm type or better still a movable grid of the Potter-Bucky type, as well as cones of various sizes. These two, grids and cones, improve the quality of the X-ray film considerably, particularly when attempts are made to take films through thick, dense structures, such as the abdomen or the skull. Also it would certainly be worth while to arrange for the addition of a *fluoroscopic screen.* Fluoroscopy is very useful in cases of suspected pleurisy with effusion, empyemas, heart conditions, fractures and dislocations. The physician may make extensive examinations with the fluoroscope at a cost much less than that of repeated examinations with X-ray films.

You might get along very nicely with a plain wooden table made to your specifications by the local carpenter, although a factory-made table would be much more convenient, especially if it could be tilted for fluoroscopy in the upright position.

Suggested Equipment Requirements

10 beds, 5 daily outpatients

	Approx. Cost
X-Ray Unit, 10-15 mA, 88kV, (1 Kilowatt)	$800.00
Fluoroscopic screen (11 x 14)	60.00
1 Cassette with screens (14 x 17)	65.00
1 Cassette with screens (8 x 10)	30.00
2 processing tanks (3 gal.)	25.00
2 film hangers (14 x 17)	6.00
2 film hangers (8 x 10)	3.50
1 darkroom safelight	5.00
1 darkroom thermometer	1.50
1 darkroom timing clock	5.00
plain wooden X-ray table)	
loading bench with) local-	
film drawer) ly	
master tank) made	60.00
view box)	
	$1061.00

20 beds, 15 daily outpatients

X-ray Unit, 20-30 mA, 88kV, (2 kilowatts)	$1500.00
Tilting table with fluoroscopic screen and Potter Bucky diaphragm	600.00
2 cassettes with screens (14 x 17)	130.00
2 cassettes with screens (11 x 14)	85.00
2 cassettes with screens (8 x 10)	55.00
2 processing tanks (3 gal.)	25.00
6 film hangers (14 x 17)	18.00
6 film hangers (11 x 14)	14.00
6 film hangers (8 x 10)	10.50
1 darkroom safelight	5.00
1 darkroom thermometer	1.50
1 darkroom timing clock	5.00
loading bench with) local-	
film bin) ly	
master tank) made	37.00
view box)	
	$2486.00

50 beds, 20 daily outpatients

X-ray unit, 75-100 mA, 100 kV complete with table, fluoroscopic screen, Potter Bucky diaphragm, etc.	$3500.00
2 cassettes with screens (14 x 17)	130.00
2 cassettes with screens (11 x 14)	85.00
4 cassettes with screens (8 x 10)	120.00
2 processing tanks (5 gal.) complete with master tank	85.00
12 film hangers (14 x 17)	36.00
12 film hangers (11 x 14)	30.00
12 film hangers (8 x 10)	21.00
1 darkroom safelight	5.00
1 darkroom thermometer	1.50
1 darkroom timing clock	5.00
loading bench with) local-	
film bins) ly	
viewing box) made	22.00
	$4040.50

The same person could also make for you a *cassette holder* which would enable your technician to take radiographs of the chest in the upright position.

Installation

Since the X-ray film is the most important single diagnostic agent and is becoming more so, it seems foolish to tuck the X-ray department off in some inaccessible part of the basement to which it is difficult to take the injured or the very sick.

The modern X-ray department should be *centrally located.* Choose a well-lighted, easily-ventilated room and provide ply board shutters for the windows so that the room may be easily darkened for fluoroscopic examinations.

If the capacity of your X-ray unit is to exceed 5 kilowatts, arrangements should be made for the power to be supplied through a *separate transformer.* This transformer should be located as close to the hospital as is possible, and a supply line should run from it directly to the X-ray department. *No other electrical equipment in the hospital should be allowed to draw current from this transformer.*

Developing and Film-Loading Room

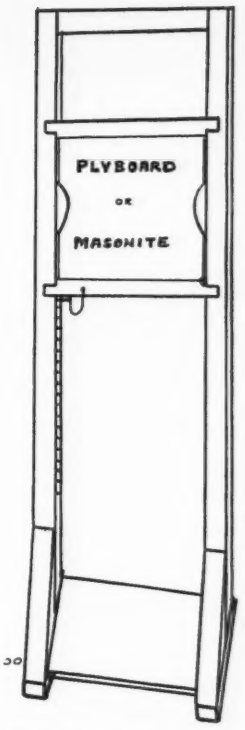
The success of dark room procedure does not depend entirely upon the developing and fixing of films. It is also affected by many other factors, two of which are very important and warrant your attention when planning the dark room.

1. The *storage* of unexposed films: Such storage space must be kept clean and dry. The most convenient place to store films would seem to be in bins built under the loading bench.

2. The provision made for *drying* films: The rack for holding wet films should be placed above the wash tank.

The amount of floor space and the size of the developing and fixing tanks will be governed by the expected amount of work. In any case, the floor space should be such as to permit the placing of the loading bench together with its film bins in such a way that there is absolutely no danger of splashing from the processing tanks during development, fixation, washing and drying. Intensifying screens are very sensitive and delicate objects. When spotted with developer or fixer, they will carry the evidence for all time, resulting in strange marking on every film taken. These markings, which we call *artefacts,* are very confusing to the person interpreting the film, especially if that person is a consultant who knows nothing of local conditions.

A *master tank* should be provided into which are set the tanks containing the developer and fixer, with space between the two for rinsing and washing. Where hot and cold running water is available, it should be connected to the bottom of the master tank and an overflow provided at the top so arranged that there is a cross flow of water. The master tank should also have a valve-controlled drain so that it may be emptied and cleaned when the solutions are changed.



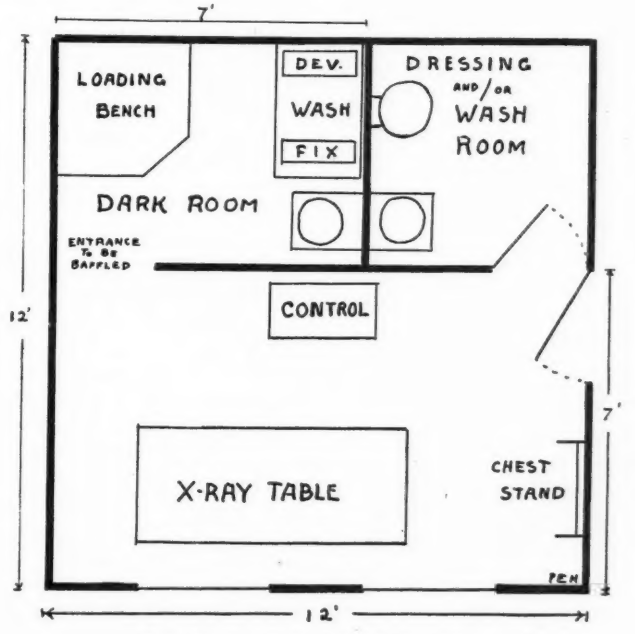
Upright Cassette Holder.

Height about 6'6", width about 2', depth at base about 1'6". Cost, material and labour, if made locally, about $20.00.

Since it is essential that the developing and fixing solutions should only be used at temperatures between 65 and 70 degrees Fahrenheit, some measure of control must be provided to keep the temperature fairly constant. Where hot and cold running water is not available, the technician must drain some water from the master tank to heat or to chill. A tap at the bottom of the master tank will permit this to be done easily, and the whole assembly should be set high enough to permit placing a pail beneath this tap.

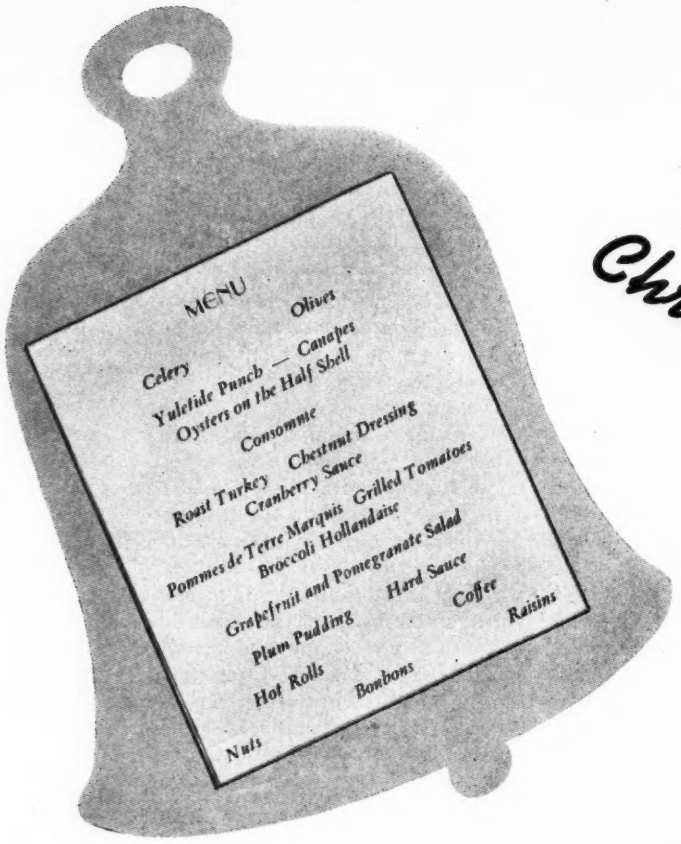
Tight-fitting covers should be provided for the developing and fixing tanks to minimize oxidation and evaporation of these solutions. Developer left exposed to the air, even though

(Continued on page 48)



Plan for Small Hospital Laboratory.

It's Still a Merry Christmas



NO, gentle reader, this is not a suggested Christmas menu for 1942. This *was* served to the patients in one of our larger hospitals—but away back in 1935! If she tried to serve that menu to-day the hospital dietitian would run up against a number of snags. Let us see what war and the high-cost-of-living have done to it.

Olives—Unobtainable.

Yuletide Punch—Well, it depends on what you put in it.

Canapés—With the acute shortage of personnel which exists in most of our hospitals, it is unlikely that many diet kitchens could take time off for the time-consuming job of preparing canapés.

Oysters on the Half Shell—This might be feasible in the Maritimes, but in most inland towns and cities they cost practically their weight in gold.

Consommé—Still with us. Probably most hospital Christmas menus will start with either a clear or a thick soup.

Roast Turkey—This mainstay of the Christmas dinner will be served as usual in most hospitals. Chestnut dressing, however, must be counted a war casualty. Fresh chestnuts are almost impossible to get, and the price of chestnut flour is "right out of reach" as one dietitian put it. Cranberry sauce, too, is rapidly vanishing. However, it is safe to say that there will be *some* kind of dressing and *some* kind of sauce.

Pommes de Terre Marquis—The potato ye have always with you. In fact the vegetable menu might stand as is, though a less costly substitute might be found for broccoli.

You can eat all of this apple-and-marshmallow Santa—except the cotton-batting beard and moustache.

Grapefruit and Pomegranate Salad—Pomegranates haven't been seen around these parts for two or three years.

Plum Pudding and Hard Sauce—Plum pudding, by all means. Hard sauce, well, it uses up a good deal of the hospital's scanty sugar ration. And, alas, no more brandy to burn on top!

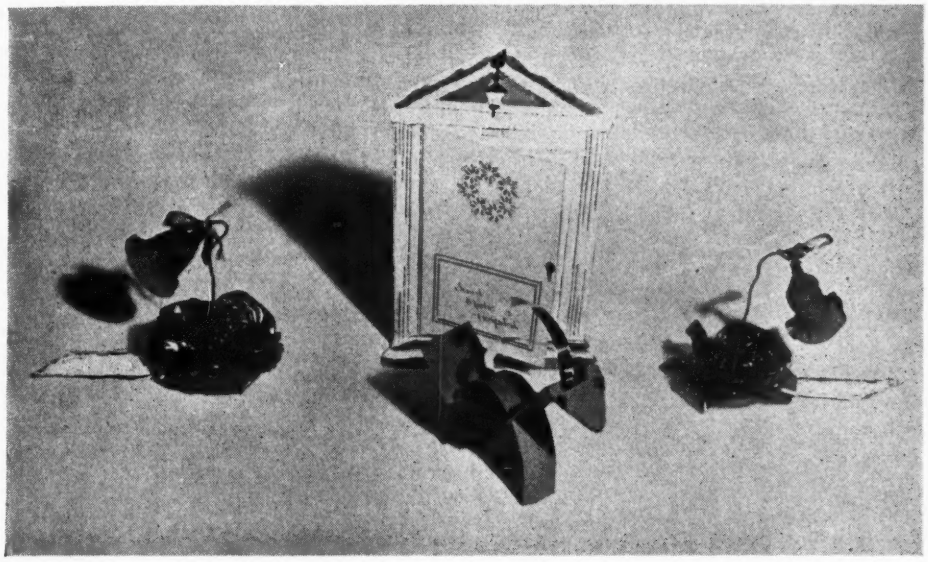
Nuts, Bonbons, Raisins—Nuts have risen so much in price as to be prohibitive in most hospitals. Bonbons take too much sugar to make. Raisins are scarce, and what can be bought will be needed for puddings. Incidentally, in most hospitals it is either Plum Pudding *or* Christmas Cake—not both.

However, the outlook is not too black. "Christmas Dinner" to most people means roast turkey and plum pudding, and both of these will be available in most hospitals.

Hospital dietitians have been giving much thought to substitutes for the usual candy and sweets. One suggestion has been green and purple grapes in paper candy baskets with a couple of peppermint creams for

added colour. Fruits stuffed with fondant or marshmallow are also being used—prunes filled with green peppermint fondant, for instance. A variety of colour combinations can be worked out by using the different vegetable colourings available. These take time to prepare, but the results are worth it—both to eye and to palate.

Where a hospital has succeeded in obtaining hard candies, these are in most cases being reserved for ward patients. In fact the greatest care is being taken to ensure that Christmas on the ward should be "Christmas as Usual". The wards will be decorated, there will be Christmas trees and Christmas parties and, according to plans, many patients will be greeted by carols early on Christmas morning.



(above) Favours for the Christmas tray. The Christmas tree contains the menu and the baskets candies. The silver-coloured sleigh is a matchbox.

(left) Behind the hospitable door in the background is the Christmas Dinner menu. The bell place-cards add a festive touch to the tray, and the very effective reindeer is made from red paper.

Children will suffer least from wartime restrictions. Most hard-hearted doctors and dietitians contend that plum pudding and rich dressings and sauces are bad for children's insides anyway. So 1942's smaller patients will have their turkey prepared in the usual way (fricasséed, for instance) and the usual dessert of ice cream in fancy shapes. And if Santa Claus does not arrive on schedule, well, it will be because *all* the hospital's male employees are worried too thin. Which is not likely.

Military Hospitals To Be Given to City

Prince Albert, Saskatchewan, will have accommodation for 100 more patients at the end of the war, when the two new hospital buildings being constructed for army use are turned over to the city.

These two buildings, a 60-bed military hospital and a 40-bed isolation hospital, are situated in the Victoria Hospital grounds, and the hospital board is defraying the costs of the basement and concrete foundation, for which provision was not made in the original plans. Military authorities are paying for the superstructure, and will also equip and staff both hospitals for the duration of the war.

On Hospital Strikes

"It has been well said that in every religion held sacred by man, the care of the sick is held to be a spiritual task, and he whose influence and behaviour interferes with such time-honoured traditions and customs must assume a responsibility not usually undertaken for trifling reasons." The sympathy of English hospital administrators will go out to their colleagues in the United States in this trial. Whatever grievances labour may have felt at times, they have never found expression in any way which would affect the care of the sick. In the worst days of the General Strike of 1926 in this country, we all knew that we were perfectly safe in the assurances given that the essential services would be maintained for the hospitals. As the hospital service plans are extended so that the men realize their partnership in the work of the hospitals, the authorities may have good hope that there will be an end to this kind of difficulty. Humane instincts in the heart of man are a surer basis for the continuance of hospital work than any number of legislative enactments.

— Hospital and Nursing Home Management.

The Subsidiary Worker

By Rev. Sister MANDIN,
St. Paul's Hospital,
Saskatoon, Sask.

IN the first place we might ask, "What is a subsidiary worker?" Generally speaking a "subsidiary worker" in a hospital is one who aids the professional nurse in a subordinate capacity. This category of the personnel comprises nurses aides, ward helpers, orderlies and attendants. The assistance given by these workers varies according to the type and size of the hospital, the standard of nursing service within the particular hospital, the social and educational status of the community which the hospital serves, and also the amount and quality of the training and guidance given to these subsidiary workers.

Before formulating any plans for the effective use of subsidiary workers, we must bear in mind the responsibility they have in safeguarding the life and health of individuals and of the community at large. Protection of the public has been, and still is, the primary objective of the nurses' associations in their effort to control all persons who nurse the sick. It is well, therefore, for hospital authorities to clearly understand the place of the subsidiary workers in the nursing service plan, and also to be aware of the dangers and abuses that might creep in if the supervision of these workers is inadequate.

A carefully thought out plan of instruction and practice must be drawn up if the best possible service is to be obtained from ward helpers. The type of service desired may vary according to the set up of the hospital in which the aides are employed, but the general principles will hold for all. In a general hospital where acutely ill patients are treated and skilled nursing is required, the subsidiary worker would assist greatly by supplementing the nurse in performing many non-professional duties, thus enabling the nurse to care for a greater number of patients. In special hospitals for convalescent, tuberculous or incurable patients the services of a non-professional person may entail at times some minor nursing care, but it must be kept in mind that the work would have to be carefully supervised by a professional nurse.

The schedule of classes and practice must be determined before the workers are admitted to the hospital. The director of nursing service or of the school of nursing should be responsible for the selection and training of the subsidiary workers. A personal interview should be required of each candidate, at which time the course should be explained to her. The classes and guidance for the aides should be given by a qualified nurse.

Outline of Course

The following outline of theory and practice is suggested:

I Hospital Organization and Administration
- a. The purpose of a hospital.
- b. The place of the subsidiary worker in hospital.
- c. Hospital etiquette and adjustments to institutional living—including talks on personality.

II Health and Sanitation
- a. Personal hygiene.
- b. Care of the patients' surroundings.
- c. Cleanliness including a brief outline of bacteriology and prevention of spread of disease.

III Hospital Economics and Housekeeping.
- a. Care of rubber goods, glassware, etc.
- b. Care of linen and removal of stains.
- c. Arrangement of flowers.
- d. Dusting and sweeping.
- e. Care of utility rooms and sterilization.

IV Principles of Bed Making
- a. Making an empty bed.
- b. Making a bed with a patient in it.
- c. Making an operation bed.
- d. Stripping a bed and washing it after the patient's departure.

V Minor Nursing Procedures
- a. Assisting patients with morning and evening care.
- b. Assisting convalescent patients with bath.
- c. Giving and removing bed pans.
- d. Helping a patient to dress.
- e. Getting a patient up, lifting and moving patients.
- f. Food service—nourishments, trays, feeding helpless patients.
- g. Collection of specimens.

Outline of Work

Morning Assembly
Assignment of work (also posted on bulletin board).
Remarks:
Mrs. X—having B.M.R. Must be left undisturbed.
Mrs. Y—going to O.R. Nothing by mouth.
Mrs. Z—very ill. Do not disturb unless told to by the nurse.
Pass and collect basins and tooth cups and assist patients if indicated.
Answer lights and report patients' wants to nurse if necessary.
Collect pitchers and water glasses, wash pitchers and glasses and give fresh water to those who may have it.
Arrange ward.
Straighten bedclothes, adjust pillows and bedside tables ready for breakfast. (Cards indicating patient "not to be disturbed" should be attached to patient's bed.)
Serve and carry breakfast trays to patients.
Feed helpless patients.
Arrange flowers.
Carry back trays.
Pass bed pans.
Help bathe convalescent patients.
Make beds of convalescent patients.
Assist nurse to turn or lift patients.
Dust, sweep and tidy wards.
Tidy service room.
Clean treatment trays, wash and sterilize utensils after use.
Place linen in closets.
Take patients to X-ray or treatment rooms.
Guard an intravenous infusion and call nurse when necessary.
Get patients up. Help patients in wheel chair, etc.
Check new patients' clothes.
Arrange the patient's unit after discharge —wash bed, tables, boil used articles, etc.
Run errands for nurses—take prescriptions to pharmacy, requisitions to kitchen, specimens to laboratory, etc.
Check weekly supplies and make report to head nurse.

Besides the routine already outlined, the ward helper may replace the kitchen maid whenever necessary. She may also help in other housekeeping duties, such as washing windows, cleaning cupboards, labelling bottles, keeping the refrigerator and medicine cabinet clean, having a supply of clean medicine glasses al-

(*Concluded on page* 44)

To Meet the Shortage of Nurses

Miss K. W. ELLIS, Reg.N.

As a special wartime measure, the Canadian Nurses Association has announced its approval of a plan for the acceleration of the basic nursing course. This plan is suggested to meet the present emergency. It is not the thought that it will be regarded as obligatory or that it will be initiated very generally .

It is realized that the proposed acceleration can only be safely undertaken in certain schools. It will call for additional and especially well-qualified teaching and supervisory staffs. Any reduction in the number of lecture hours will require most careful analysis and planning of the teaching programme in order to ensure adequate instruction being given and to protect the quality of this.

While details of the plan have not been announced, it is suggested that at the beginning of the course adjustments be made to permit the theoretical content of the students' course to be covered in two and a half years, under the most careful conditions of instruction.

In schools in which this plan might be made effective, it is the suggestion that the course would be so arranged that the student might be eligible to leave the nurses' residence at the end of *two and a half years* and carry on the work of a general duty nurse, but would still be under the supervision of her school until she completed the full three years of training. At the end of this time she would be awarded, as usual, the school diploma, and would be eligible to sit for the registration examinations.

It must be noted that this adjustment presupposes the additional cost of instruction and further expenditure for subsidizing the nurse.

Benefits

The following benefits are expected to ensue:

1. Provision for increased living accommodation.

2. Stimulation of recruitment, if the student nurse begins to earn a salary at an earlier date than has hitherto been possible.

3. A smoother and stronger nursing service in certain hospitals because more of their general duty needs will be met by their own immediate students.

4. Assistance to hospitals in need of this may be afforded by certain schools in which the authorities would be willing to permit some senior general duty service to be taken in such hospitals.

5. Experience, under favourable conditions and after sound instruction, for senior nurses that will be of real value to them in rounding out the course.

It is emphasized that even in the present emergency each school of nursing must provide the essential instruction needed to ensure safe nursing. This can only be done by supporting standards of approved schools and meeting registration requirements which have been built up for this purpose.

Married and Inactive Nurses

Another means of meeting the present shortage of nurses is included in a recommendation made by the Canadian Nurses Association to the provinces that temporary nursing permits be granted to all married and inactive nurses who were eligible for registration at time and place of graduation, and that refresher courses for married and inactive nurses be continued in all possible centres.

Miss E. Muriel McKee

Superintendent of Brantford General Hospital, who has been named President-Elect of the Ontario Hospital Association.

Lay Women in Hospital Service

The Committee on Lay Women in Hospital Service in the American Hospital Association has completed its first year of activity. This committee was authorized by the A.H.A. meeting in Atlantic City a year ago to put upon a permanent basis the inclusion of the work of women's auxiliaries among the activities of the Association. It will be recalled that Mrs. Rhynas, the Ontario president, was chairman of the first A.H.A. sectional meeting held primarily for women's hospital aid members three years ago.

This Committee operates under the Council on Association Development and had charge of the Women's Auxiliary portion of the programme at the St. Louis meeting this autumn. Mrs. Rhynas is a member of this Committee.

Thomas Cox

As we go to press we are informed of the death of Mr. Thomas Cox, business manager of the University Hospital, Edmonton, Alberta. Further notice will appear in our next issue.

War Savings Certificates Won at O.H.A. Meeting

Among the many interesting events at the recently completed Ontario Hospital Association convention was the special War Savings Certificate draw for ten lucky winners at the Hygiene Products display. The lucky winners listed below are to be congratulated on their good fortune:

Ivor H. Hunt, Wellesley Hospital, Toronto; Sister Mary Francis, St. Michael's Hospital, Toronto; Sister Mercedes, St. Joseph's Hospital, Toronto; Miss Grace Cornwall, Kitchener-Waterloo Hospital; Sister M. Cordula, St. Joseph's Hospital, Hamilton; Mr. J. J. Clark, G. & M. Hospital, Owen Sound; Mrs. G. W. Houston, Hamilton General Hospital; Mrs. Lloyd Deegeu, Civic North Bay Hospital; Miss E. Wrenshall, Canadian Hospital Council; Sister Anna Teresa, St. Joseph's Hospital, Port Arthur.

Canadian Intern Board Continues to Function under Trying Conditions

By J. G. R. SOLMES, B.A.,
Secretary, C.I.B.

THE Canadian Intern Board has just completed its fourth and most successful year. The Board had anticipated many difficulties due to the speeding up of medical courses and the increased tempo of the war. However, we are happy to report that no insurmountable difficulties arose and that we were able to supply a most useful service to both hospitals and medical graduates.

Below is a table indicating the scope of our work. From this we may note:

(1) This year we have dealt with 166 medical graduates. Of these the Board has been able to place 139 or 84 per cent in hospitals of their first choice. This is an increase of 12 per cent over the previous year.

(2) Only 3 per cent of students dealt with failed to receive appointments immediately through the Board. These few, however, were sent lists of hospitals that could not obtain their full quota of interns. Most, we are happy to say, now have their appointments.

The students making use of the Board found it very useful and were, in almost all cases, well pleased with the results obtained.

Hospitals

The Board dealt directly during the year with 32 hospitals approved by the Canadian Medical Association. Of these hospitals most dealt solely through the Intern Board and co-operated with it to the fullest extent. We should like to thank these hospitals for this co-operation and we trust that it will continue in the future. These hospitals feel, as we feel, that the interests of both the student and the hospital are looked after and protected by the Canadian Intern Board.

As for many years back, there was a discrepancy of at least 25 per cent between the hospital needs and the available graduates. The Canadian Intern Board, of course, can do nothing about such a situation but it is interesting to us this year to note that the distribution of graduates is much more uniform than in the past. Unfortunately some of the larger Canadian hospitals this coming year will be somewhat short of interns, and their intern staff will consequently have a heavy burden of work but, on the other hand, many more of the smaller hospitals have achieved a more or less adequate intern staff for the coming year.

Difficulties

We may truthfully say that our difficulties this year were much less than we had anticipated. Most of the hospitals that dealt with us were pleased with the results obtained. Our chief difficulties arose from hospitals which failed to co-operate with the Board or those which, while appearing to co-operate, failed to live up to their agreement completely in this regard. These, however, formed a small minority.

Suggestions

The Canadian Intern Board would like to enlist the co-operation of all the approved hospitals throughout Canada. We feel that your intern problem is much simplified by dealing through the Canadian Intern Board. By using this method you protect yourself against the high pressure tactics of other hospitals, simplify your dealings, and still ensure as large an intern staff as you could possibly obtain by dealing directly with the students. This is particularly true since such a large percentage of Canadian graduates now depend upon the Intern Board for their appointments. Of particular value, your appointments are settled much sooner than under the old system. We welcome enquiries as to the method of allotment and as to the relations of hospital and graduate under this scheme. All correspondence should be addressed to The Canadian Intern Board, 107 Anatomy Building, University of Toronto.

Results of Intern Placements by C.I.B.

University	*Hosp. Choice Obtained by Student*				*Unplaced*	*Total Students dealt with*
	First	*Second*	*Third*	*Fourth*		
Laval	2				0	2
Queen's	25	4	2		2	33
Toronto	85	7	4	3	3	102
Western	27	1	1		0	29
Total	139	12	7	3	5	166
Per cent	84%	7%	4%	2%	3%	

Hark! The herald angels sing
Glory to the newborn King!

B. C. Hospitals Association Holds Lively Convention

VITAL problems affecting hospital administration in wartime were discussed at British Columbia Hospitals Association convention held in Victoria on November 3-4-5. Delegates from over forty B. C. hospitals attended.

Members were welcomed by the Hon. George S. Pearson, honorary president of the Association, who spoke of the probable reorganization of hospitals after the war. He suggested that a more equitable distribution of hospital facilities would almost certainly result, and that the master hospital plan might be adopted for larger urban centres.

Some heated discussion of the problem of rates for the hospitalization of Indians followed, and the matter was referred to the resolutions committee. Ernest Mayon of Merritt suggested that all hospitals notify Ottawa that after April 1st, 1943, no Indian patients would be admitted except at regular rates.

Percy Ward, Inspector of Hospitals for the provincial government, reported one more hospital than last year, but noted that the capacity of the institutions had been decreased from 5,017 beds to 4,861.

Mr. O. H. Bell, who is regional superintendent of rationing for British Columbia, dealt with this vexed problem in a clear and sympathetic manner, and brought home to his listeners the benefits of the price control and rationing system by a comparison of the cost of certain staple articles today and during the same period of the last war. Mr. Bell also pointed out that the collection of rationing coupons in hospitals was necessary in order to remove them from circulation.

Mr. J. H. McVety, the association secretary who is also regional superintendent of employment and National Selective Service for British Columbia and the Yukon, warned the delegates that Canada is not yet on a 100 per cent war footing, and that to achieve this end more and more materials and labour would have to be diverted to strictly war and essential industries. The present labour shortage could only be met by the closing down of non-essential industries. It would also appear that "workmen are probably going to be required to work longer hours, and women will be employed everywhere possible".

Miss K. W. Ellis, Emergency Nursing Advisor, Canadian Nurses Association, reviewed the steps being taken to relieve the shortages of nurses in Canada. These include the shortening of the present nursing course, the elimination of private duty nursing where not strictly neces sary, a campaign, assisted by the gov ernment, to encourage the recruitment of student nurses, and the calling back of inactive and married nurses. "Whatever action is taken to produce order out of the present confusion," she stated, "it would seem that this should be the result of co-operation between hospital authorities, doctors, nurses and other professional groups. The interests and re sponsibilities of these groups are inseparable."

Mrs. E. M. Darby presented a report on the work of the Women's Aids of the hospitals. There are 14 active auxiliaries in the province, with a membership of some 900 women. During these days of labour and material shortages in hospitals, the value of an active aid is being realized as never before. Each auxiliary must study the individual needs and problems of its own hospital and contribute its supplies and services where they can be most usefully employed.

Officers

The following are the officers for the year 1942-43:

Hon. President—Hon. Geo. S. Pearson;
President—S. M. Cosier;
1st Vice-President—T. W. Walker. M.D.;
2nd Vice-President—J. V. Fisher,
Hon. Treasurer—J. H. McVety;
Secretary—E. W. Neel.

Maritime Hospital Association Seeks Incorporation

At a meeting in October of the Executive Committee of the Maritime Hospital Association the constitution and bylaws for the new organization were formulated and an application for incorporation of the association has been made. This was considered advisable in view of the intention to have a hospital care plan operated under the direction of the association.

Some 15 members were in attendance and the meeting was continued for two days under the chairmanship of the president, Dr. Joseph A. McMillan of Charlottetown. Miss Ruth C. Wilson of Moncton is secretary of the new association.

Dr. McMillan later spent some time in Montreal and Toronto where he studied the hospital care plans for Quebec and Ontario and also represented the maritime hospitals at the conference on personnel problems with National Selective Service at Ottawa.

A hospital library is invaluable as a sedative in case of worry, stimulant in case of depression, tonic in case of failing mental appetite, and as a specific for what ails all sick people.

Papuan native of New Guinea receiving medical attention from an Australian Army Medical Officer.

(Photograph Courtesy Australian Department of Information)

Obiter Dicta

Employment Situation Acute

THE employment situation in hospitals is not showing the improvement which was anticipated when the new National Selective Service regulations came into force last September. Repeated complaints are received that no help is being provided. Where potential employees are discovered, they are frequently being ordered elsewhere when they go to get their permit. Instructions seem conflicting. The hospital representatives were definitely told in Ottawa on October 22nd that for female help hospitals ranked right with war industries; regional officers have since denied this. Some regional offices will not permit a hospital to advertise for three days—others are quoted as saying that there is no such regulation.

We realize the almost insuperable task confronting these officers; we are in full sympathy with the purpose motivating this whole development and would like to see the authorities given adequate power to overcome the selfish interests that hamper the work. Much thought is being given at Ottawa to finding a solution. But overworked administrators and voluntary boards of trustees, worried with their own personal problems, cannot continue to be responsible for the care of the sick public when it is not known, from day to day, whether there will be any meals or any heat. Moreover, hospital personnel frequently attack hospitals, meaning administrators and trustees, in the press and elsewhere, as if the hospitals were to blame for present conditions.

One of these days some hospital may precipitate an issue. In sheer desperation, it may (1) close down completely or (2) decide to pay the inflated wages now paid in temporary war industry and raise the price of all beds one or two dollars a day to meet this added cost. It might even close down its public or low cost wards. Either of these measures would be drastic and would raise all kinds of complications, particularly with the government if public wards be closed for financial reasons. But *something must be done* and the answer lies, not with the hospitals, but with the public—who cannot expect to have service without paying for it—and with National Selective Service.

Doctor Sigismund S. Goldwater

THE hospital field has lost one of its greatest leaders in the death on October 22nd of Doctor Sigismund S. Goldwater. He was one of the first men to make hospital administration a specialty career. His achievements as administrator of Mount Sinai Hospital in New York City quickly marked him as a leader among hospital workers, and it was not long before he was in demand all over this continent and abroad as a consultant and advisor on hospital organization and methods and on hospital construction. Many of the finest hospitals in this country have profited greatly by his services as consultant in years gone by. Several years ago he was called to Russia to assist in the planning and organization of the great Institute of Experimental Medicine in Leningrad.

Doctor Goldwater was always deeply interested in the welfare of the whole hospital movement. He was president of the American Hospital Association back in 1908, and was primarily responsible for the radical re-organization of the A.H.A. which resulted in the grouping of all study committees under seven major councils embracing many sub-committees. In the beginning there was only one council, over which he presided. At that time the writer was a member of this Council and still recalls the comprehensive viewpoint and vision with which Dr. Goldwater directed the many fields of study.

At a time of life when most men are dropping out of active work, Dr. Goldwater undertook the greatest task of his career—Commissioner of Hospitals for New York City from 1934 to 1940. He built up one of the finest hospital systems enjoyed by any city in the world. He found it necessary to overcome political obstacles which would have cowed most men in short order, but it is a tribute to Dr. Goldwater's courage and inflexible honesty that in the later years of his administration all opposition and interference was swept aside.

Resigning this post when all was running smoothly, he undertook yet another heavy task, that of President of the Associated Hospital Services of New York, the biggest hospital plan on the continent and one of the most difficult to administer. Last winter he took up the cudgels on behalf of voluntary effort as against federal control, and

that voice and pen—now forever stilled—quickly became the most powerful opponent of this phase of the Washington programme.

He was a great man and the hospital field will never realize to what extent and in how many ways hospitals and their patients are indebted to him.

With unbounded vision of what might be done with more efficient methods of organization, he found life all too short to accomplish what he saw should be done. Sitting with him at dinner one night, he put his hand on mine and said: "I would give everything I have or have ever done to be able to turn the clock back twenty years. Time is so short and there is so much to be done."

The 4 P.M. Deadline

IN AN effort to ease the strain upon an overtaxed nursing service, the Ottawa Civic Hospital has asked permission of the Provincial Department of Health to permit it to insist upon all admissions being before 4 p.m., except, of course, in case of emergency or of special circumstances. Anyone familiar with hospital administration knows the difficulties created by patients who come in at any hour convenient to them and thereby complicate badly the work of the hospital, particularly of the nursing and dietary departments. This proposal has received much press notice and comment.

We will be interested in seeing how this regulation, if permitted, will work out. It will not be easy to enforce unless full co-operation of the medical staff be given and much public education provided. Co-operation of both the profession and the public should be forthcoming for, obviously, this is an effort to solve a difficult situation and should be so recognized. There will be some people who will protest to high heaven, but there always have been some who put their personal convenience before the common weal. By itself, such a regulation cannot be expected to solve the problems of nurse shortages and of overcrowding, but each measure to simplify the task of rendering services contributes to that extent towards more efficient operation.

Elsewhere we report a "rationing" of maternity service to the unprecedented numbers of expectant mothers now noted in so many centres. This idea may spread and may be extended to other services in hospitals. It is fast becoming realized that only by such measures can hospitals in many communities continue to meet the more serious needs of their communities.

Watch Your Narcotics

AN increasing number of robberies involving narcotic supplies emphasizes the necessity of safeguarding stocks on hand in hospitals and in doctors' offices. The serious shortage of narcotics since the outbreak of war has been felt even more heavily in the illicit trade than among those who deal through legitimate channels. The result, we are informed, has been a definite increase in widespread and apparently well-organized attempts to obtain access to supplies in drugstores, in doctors' offices and cars, and in hospitals.

The techniques followed in purloining narcotics from drug stores and physicians' offices, are seldom successful in hospital pharmacies, for outsiders are not, or should not be, admitted and the lament of the lost prescription or bottle is seldom applicable. Losses of narcotics in the hospital pharmacy are more apt to be an inside job among the hospital personnel with access to the department.

The greatest menace is on the ward where wandering up-patients or visitors may seize an opportunity to explore the medicine cabinet. Frequently this is situated in an all-too-accessible location and, sometimes, its hidden location back in a corner may also facilitate robbery. Nearly all hospital medicine cupboards have a narcotic section which is supposed to be kept locked. This is a sound precaution and is required by the narcotic control authorities, but there is evidence that in some hospitals, and perhaps in others, there are occasional times when the cabinet is not locked, or when the key is too readily available. We must remember that most addicts pass as normal citizens, even to their friends. Now, with the narcotic shortage and with so many new personnel coming on staffs, it is more important than ever to check up on our methods of narcotic control.

Anxiety Neurosis

MEDICAL officers who have returned from overseas speak of a condition among the soldiers which has very variable symptomatology, is often difficult to diagnose and sometimes still more difficult to clear up. This is becoming known as a form of "anxiety neurosis". It would appear that frequently some loved one at home is sick; perhaps letters have not been received because of submarine activity, or perhaps they have been delayed through transfer of the soldier; or the wife may worry him over her financial difficulties, her effort to make the best of things being not helped in the slightest by sections of the press trying to embarrass the government. The very monotony of his life in camp may aggravate his worry and anxiety. Under such conditions functional neuroses with little or no organic evidence of disease, may be developed.

The R.C.A.M.C. is very much alive to this situation, for it realizes that a soldier sick at heart is not able to do his best for his country. The real cause of the symptoms is not always easy to find—men do not talk easily of their inner worries to strangers, even though their interrogator be a physician. Nor does the unearthing of the offending factor effect a cure, for much enquiry and some delay may be necessary to produce adequate evidence that everything is really all right at home. Without realizing it, our hospitals have done much to prevent a drop in the morale of the men overseas by the excellent quality of the service which they have rendered to the wives and dependents of these men. Irrespective of their ability to pay, hospitals have continued to render a remarkable health service to our civilian population, frequently under circumstances which make the achievement all the more noteworthy.

With the Hospitals in Britain

By "LONDONER"

C. E. A. Bedwell

Further comments on a decision of serious concern to Canadian and other British hospitals.

Dear Mr. Editor,

The case of negligence by a radiographer of which particulars were given in my letter published in your June issue has had an important development. It is not too much to say that it will affect hospitals in the Dominions as well as at home. Hitherto, as in this case, the Courts have felt themselves obliged to follow the decision in *Hillyer* v. *St. Bartholomew's Hospital* of which the practical effect was that if the hospital authorities had taken due care in appointing a member of the staff —nurse or technician—then they could not be held liable in damages for any act of negligence in the course of the execution of his professional duties. This was the issue raised by the friends of the little girl Gold permanently injured on the face by the negligence of a radiographer employed in a hospital by the Essex County Council. Encouraged no doubt by Mr. Justice Tucker's observations, they appealed from his decision to the Court of Appeal which has the same status as the Court responsible for the decision thirty years ago in *Hillyer* v. *St. Bartholomew's Hospital.* The latter included Lord Justice Farwell and Lord Justice Kennedy whose observations have been frequently discussed judicially and so far as they have influenced Canadian decisions were admirably surveyed by Mr. F. N. MacLeod in the Sir Joseph Chisholm prize essay at Dalhousie Law School on "The Liability of a hospital for the negligent acts of a nurse" published in the *Canadian Bar Review* 1940 (Vol. xviii, pp. 776-793).

A Strong Court

Lord Greene, the Master of the Rolls, Lord Justice MacKinnon and Lord Justice Goddhard constituted the Court to hear the appeal and proceeded to discuss the legal position in which they were invited to overrule the decision of their predecessors. They did so by what lawyers call "distinguishing" the facts of and reasoning in the earlier case. They appreciated that they were dealing with judgments which had been frequently adopted with or without modification in the Courts of the Dominions as well as those of England and Scotland. At the same time the Court recognized that there had been a good many conflicting views and endeaoured to establish some plain principle for future guidance.

A Basic Principle

An examination of the relationship of the hospitals to their staffs led to the conclusion that it was one of "master and servant". Throughout the Court referred to the nurses as illustrative of the various types of staff other than medical. Having established that position it followed in law that the hospitals were liable for the negligent acts of their servants. They dismissed the distinction between administrative and professional acts but introduced a new *ratio decidendi*. "The true ground," said Lord Greene, "on which the hospital escapes liability for the act of a nurse who, whether in the operating theatre or elsewhere, is acting under the instructions of the surgeon or doctor is not that *pro hac vie* she ceases to be the servant of the hospital but that she is not guilty of negligence if she carries out the orders of the surgeon or doctor, however negligent those orders may be!" The Court found that the radiographer was acting on his own responsibility and according to his own judgment. "He was in no sense," his Lordship added, "under the orders of any medical man save as to the nature of the treatment and the dose." Accordingly the County Council were held to be liable for his negligence and have had to pay £300 to the child. This, however, is by no means a simple basis upon which to reach a decision, as the Supreme Court of Canada found in the well-known case of *Nyberg* v. *Provost Municipal Hospital Board.*

The Position of Council Hospitals

When *Hillyer* v. *St. Bartholomew's Hospital* was decided at the beginning of the century there was practically no general hospital work being done by hospitals controlled by local authorities. Although the English Courts have never made the distinction drawn by the Courts of the United States between charitably supported institutions and those deriving their income from public funds there has undoubtedly been a bias in favour of voluntary hospitals because the patient is the recipient of charity and their funds are derived from that source. Developments in the last ten years have entirely altered the work of the Council hospitals and at the same time increased the number of claims as patients have no hesitation in attempting to get damages from public funds. Bodies appointed by popular election are very susceptible to public opinion and often pay up to avoid the contumely likely to arise from contesting an action. Under an Act of Parliament passed in 1936 the local authorities have a definite duty to treat as well as to maintain the patient. The Courts considered that this in itself was sufficient to make the Essex County Council liable to pay damages to the child Gold but preferred to put their decision on a wider basis and definitely to include the liability of voluntary hospitals.

The Liability of the Medical Staff

The point upon which the Court experienced some difficulty was the liability of the medical staff. They decided that consultants whether attached to council or voluntary hospitals must bear their own responsibility and the local authority could not be liable. But the whole-time medical superintendent is in a different

(*Concluded on page* 42)

Abbott announces a large volume intravenous solution with important B Complex factors

● Recently it has been recognized that the task of metabolizing post-operative intravenous feedings of dextrose in a patient already having a reduced store of the B Complex group of vitamins may exhaust that store and result in acute deficiency. Consequently, a number of investigators state that it is a wise prophylactic measure to administer thiamine hydrochloride, riboflavin and nicotinic acid to all patients who receive dextrose fluids parenterally. ● To satisfy the need for a large volume parenteral dextrose-saline solution containing these B Complex factors, Abbott Laboratories has developed Beclysyl. ● This solution, while suitable for use in all cases requiring the parenteral administration of dextrose in saline, is particularly indicated in post-operative states associated with nausea and vomiting, hyperemesis gravidarum, and in cases where intestinal obstruction or other intra-abdominal disease would cause persistent vomiting. ● Each liter of Beclysyl contains in chemically pure water free from pyrogenic substances: 50 Gm. Dextrose ; 8.5 Gm. Sodium Chloride; 3 mg. Thiamine Hydrochloride; 3 mg. Riboflavin; and 25 mg. Nicotinamide. ● Beclysyl is supplied in a special Abbott Liter Container coated with a black lacquer to protect the riboflavin content. Two readily removable strips of tape, one on each side of the bottle, allow the operator to determine the solution level during administration.

Beclysyl

TRADE MARK

ABBOTT LABORATORIES LIMITED, MONTREAL, CANADA

The Press Is Co-operative

By Mr. S. N. WYNN,
Yorkton, Sask.

Hospitals rank with the most important businesses in their respective communities in the matter of revenue and expenditures. If these hospitals were under one central management, operated in some such way as the banks, the railways or the chain-stores operate, there would be set up a public relations bureau at the head office, which would be considered a most essential part of the organization.

Hospitals, on the other hand, not only have no public relations officers, but in many cases have a distinct, though perhaps unrecognized attitude of resistance towards advertising and publicity.

From an address given at the Saskatchewan Hospital Association Convention in September. Mr. Wynn is both a trustee and an editor.

To be successful, hospitals must adopt the methods and practices of modern organized business. All successful businesses strive to cultivate and retain the goodwill of the public. Hospitals could profit greatly by adopting their methods.

I do not suggest that public relations departments be set up, or that advertising appropriations be made. This is neither necessary nor desirable. The press of any community will gladly assist in promoting such an important and essential service as that provided by the hospital if the right relationship be established. If this condition does not exist administrators or boards should see that steps are taken to remove misunderstandings by providing the newspaper with the kind of news that will stimulate interest in the hospital, promote goodwill and gradually create in the public mind a feeling of pride and confidence and appreciation of the dignity of hospital service and the essential nature of its work. This cannot be accomplished overnight. Results come slowly and quietly.

A friendly understanding and relationship involve no greater obligation than ordinary courtesy and willingness to co-operate by providing the press with reasonable information about the facilities and services of the hospital. Hospital policies and hospital difficulties can be dealt with in a helpful manner if handled in the right way. Stories about its equipment, plans for expansion, difficulties due to loss of trained personnel—all can be given to the public in a way that will ensure goodwill and co-operation. The press can be a helpful ally or a big headache. The choice will be determined in most cases by the attitude of the board or the administrator.

Basil MacLean Lets Chips Fall Where They May

The American College of Hospital Administrators means business in its efforts to produce a high standard of hospital administration on this continent. One of the most stimulating papers at its very successful meeting in St. Louis last month was given by Dr. Basil MacLean, President of the American Hospital Association, speaking on the subject: "Hospital Administration—Up or Down?"

Haywood-trained and fearless, Dr. MacLean went to the platform virtually with a dissecting set in one hand and a meat-grinder in the other.

"Administrators," he said, "have made little progress. They are little more than innkeepers.

"Are we content always to accept the opinions of others—or do we read at all? . . . There are too many papers and public articles on getting extra nickels and handling prima donna doctors and trustees, and too few on research and progressive development. . . . What interest have we in economics? . . . Too many of us are content to be cash registers, floor-walkers and apple-polishers.

"Humility and humour are two very essential characteristics but they can be carried too far. Too many administrators are looked upon merely as a combination bookkeeper, housekeeper and back-slapper.

"Uriah Heeps are still too frequent among us—the only difference being that we do not always combine shrewdness with servility. Many administrators do not properly control their staff weaknesses. Some seem to follow the motto: 'Never stick your neck out'."

Speaking on public relations, Dr. MacLean noted that he had recently seen the billhead of a hospital which had typed under the name of the hospital: "Faith, Hope, and Charity—and the greatest of these is Charity." Under that was an item: "Aspirin, 10 grains—25 cents."

Dr. MacLean did not share the common belief that physicians are the anointed among administrators. "An M.D. degree is not a passport to administrative ability". There are good and bad among both medical and lay administrators.

The speaker, who has just completed a Sabbatical year studying public health, anticipates that our public health services will expand greatly and that hospitals will become strategic instruments in the field of public health. "In Great Britain the administrator is often the local health officer. This might be a good arrangement here. There would be more opportunities for our hospitals to serve the community if we as administrators took an interest in immunology, sanitary engineering, industrial hygiene and other health subjects."

Hunger in Belgium

The food situation in Belgium is very grave. The death rate for January for the whole of Belgium was 21.5 per 1,000—almost the same as that for Austria at the height of the famine after the last war. In hospitals the death rate among children under six has increased by 300 per cent since before the war, and the number of premature deliveries has quadrupled.

Malnutrition diseases, such as rickets and tuberculosis, are increasing rapidly. Games are seldom played at school, for the children are too weak, and the normal routine of school is considerably disorganized by frequent absence and fainting.

Here and There

By the EDITOR

ONE of the delightful features of the triple biography "The Doctors Mayo" by Helen Clapesattle is the large number of fleeting but fascinating glimpses which it gives us of so many people whose paths have crossed or influenced those of the Mayos. For instance, there is "Jay", the short, pudgy, baldheaded janitor and general boss of the establishment, who chewed tobacco, ate onions and swore "not offensively, just easily and constantly." Though repeatedly "fired" for his bullheaded independence he never paid the slightest attention to these orders, but calmly carried on—in his own way.

"One of his many duties was to file the correspondence, and he was fabulous at the job. He simply pasted the letters end to end as they came,—alphabetically or chronologically only by chance—and rolled them into a cylinder. To find a letter he unrolled it like a scroll. Then someone must have shown him how druggists filed their prescriptions, for he suddenly began stringing the letters one upon another on a length of wire or heavy twine. A far cry from the precise folders and files of the Mayo Clinic division of correspondence!"

Then, too, there was the young prescription clerk in the drug store downstairs in whom the "Old Doc" became interested. Teaching the lad what he could of chemistry and physics, he urged the boy to go away and study pharmacy properly. Encouraged, the young boy did so and later went abroad for further study. Getting work in London with a chemist named Burroughes, he soon married his employer's daughter, and so Henry Wellcome, later Sir Henry, was launched on his great career of international business, research and philanthropy.

Years ago Dr. Will bought a shining new Pierce Arrow car. The Old Doctor, showing it to a visitor, the famous Dr. Carl Beck, suggested a ride. He had started the motor and was about to drive off with the distinguished visitor when Dr. Will rushed out and breathlessly explained to Dr. Beck that his father had never driven a car in his life!

The mother of the boys was a woman of character equally as sturdy as that of her doughty husband. On one occasion when well advanced in years, the plump "Madam Mayo" spied some pumpkins through a barbed wire fence. She asked the chauffeur to stop so she could *steal* one. He offered to get it for her, but she said "No, you have to steal it yourself; then it brings you luck." So she climbed over the fence and got the pumpkin.

Her chief delight was in taking an active part in the work of the Episcopal Church. "But domestic matters sometimes stalked her, even at divine worship. Rochester folk long chuckled about the time she almost disrupted the Sunday morning service. In the midst of it she suddenly jumped to her feet, cried aloud, 'Godalmighty, I left my bread in the oven!' and went streaking up the aisle towards the door."

* * *

"'Tis an Ancient Custom"

An interesting paragraph appears at the end of a volume published in 1661, entitled "God Made Man. A Tract Proving the Nativity of our Saviour to be on the 25th of December". Purged of the old-style printing that makef thefe old manufcripts fo quainte but fo well-nigh impoffible to read, it runs as follows:

"These are to give notice, that the true and right Lozenges and Pectorals so generally known and approved of for the cure of Consumptions, Coughs, Astama's, Colds in general, and all other Diseases incident to the Head, are rightly made only by *John Piercey*, Gent. the first Inventor of them; and whosoever maketh them besides, do but counterfeit them: they are to be sold by *Nath. Brook* at the Angel in *Cornhill.*" (Nath. Brook, by the way, is the publisher of the Tract. He was apparently not above picking up a little money on the side.)

Somehow the quotation has a modern ring to it. How about: "Refuse to accept substitutes—insist on genuine ————'s Liver Pills." Or: "If it isn't ——— it isn't ———!"

It is all very reminiscent of the *Punch* cartoon showing the dignified president of the Toasty-Woasty Biscuit Company addressing a meeting of the shareholders:

"Gentlemen, I am happy to inform you that the Goody-Woody Cooky Company, Inc., has agreed to discontinue referring to us in their advertising as 'inferior brands' if we in turn will cease to call them 'dubious substitutes' ".

* * *

Have We Been Missing Something?

"After considerable observation, I have come to the conclusion that most girls expect to be kissed when they are taken home" stated Dr. H. C. Boughton, Medical Superintendent of the Saskatoon Sanatorium, at the recent provincial hospital convention. He was discussing the danger of short but frequently-repeated exposure to bacilli as a cause of tuberculosis. This common practice, he asserted, is probably the cause of many breakdowns. Of course Dr. Coughton explained that he gained this knowledge by questioning many girls, presumably in the clinics.

Whereupon the superintendent of a large school for nurses, who really looks too attractive to hold such opinions, demanded in no uncertain terms that "this silly custom of kissing should be banned"! Another said, less audibly, "I agree. I can't see what the girls see in it"—whereupon a man who looks past that stage but probably hopes he never will be, informed her that you are not supposed to see—you close your eyes.

Whereupon the lecturer proceeded and the meeting did not banish front-porch kissing forever.

People who stay home because they think conventions are stuffy miss a lot of information.

Ontario Conference, C.H.C., Hears Stimulating Addresses

By REV. SISTER ST. ALBERT, Secretary

THE chairman of the Programme Committee of the Ontario Conference, having in mind the possibility of conventions being cancelled for the duration of the war, put as much encouraging and stimulating material as possible into the programme of the tenth annual convention, held in Toronto on October 27th.

The reports from the various committees of the Association were ample evidence that these committees were cognizant of their responsibilities and had been most active.

Mr. Arthur Kelley's clear and simple interpretation of recent legislation affecting hospitals in Ontario was much appreciated.

Sister Mary Francis, in her excellent paper, "The Hospital Dietitian's Participation in the National Nutrition Programme," stressed the fact that the Canadian people must obtain more calories from the protective foods and that the hospital dietitian's immediate concern is to *see* that patients and staff get these protective foods in sufficient amounts. The diet of our patients, Sister stated, usually does receive proper supervision. However, the diet of the staff needs study and supervision also, if the "arch saboteur" (hidden hunger) is to be kept at bay.

Reverend Father Keating, S.J., in his encouraging address on "The Spiritual Life of the Hospital Sister in a Time of National Crisis" encouraged his listeners to put first things first and in their daily ministrations to radiate Christ by being Christlike.

The afternoon session was given over to the study and discussion of the nurse—her educational, professional and spiritual guidance.

In his paper "Individual and Group Spiritual Guidance of Student Nurses in our Catholic Schools of Nursing," Father H. W. Daly, S.J., emphasized the necessity of a living and functioning Sodality to help the nurses develop into spiritual women.

In her paper, "Educational and Professional Guidance of Student Nurses in our Catholic Schools of Nursing," Sister Henrietta, St. Louis, made a strong plea for an organized plan. Quoting from the Council on Nursing Education, Sister concluded: "A Catholic School of Nursing, which by reason of its religious convictions and its philosophy of education is imbued with a strong sense of responsibility for the human individual, will seek to express its entire concern for the spiritual, educational and professional development of the individual student through emphatic emphasis on its guidance programme."

Sister Mary Susanne, who spoke on "The Library of the School of Nursing" pleaded for a full time or at least a part time librarian who would also be a member of the faculty.

The symposium on "The Ward Teaching Programme" was of a very practical nature and gave evidence of the keen awareness of the participants of the vital necessity of this phase of nursing education.

In the evening Doctor Agnew talked to the group, in his clear and lucid style, about priorities, rationing and price control. Doctor B. T. McGhie, Deputy Minister of Health and Hospitals, gave a sympathetic and practical address on "Hospital Service for Civilian Casualties." Sister Vincentia, who thanked the speakers, expressed the sentiments of the listeners when she informed Doctor Agnew that she did not realize that a *man* could understand our problems so well and to Dr. McGhie when she told him that he had made the picture of the bombing of England so vivid that we unconsciously looked about for our Chaplain and were relieved to see him in our midst.

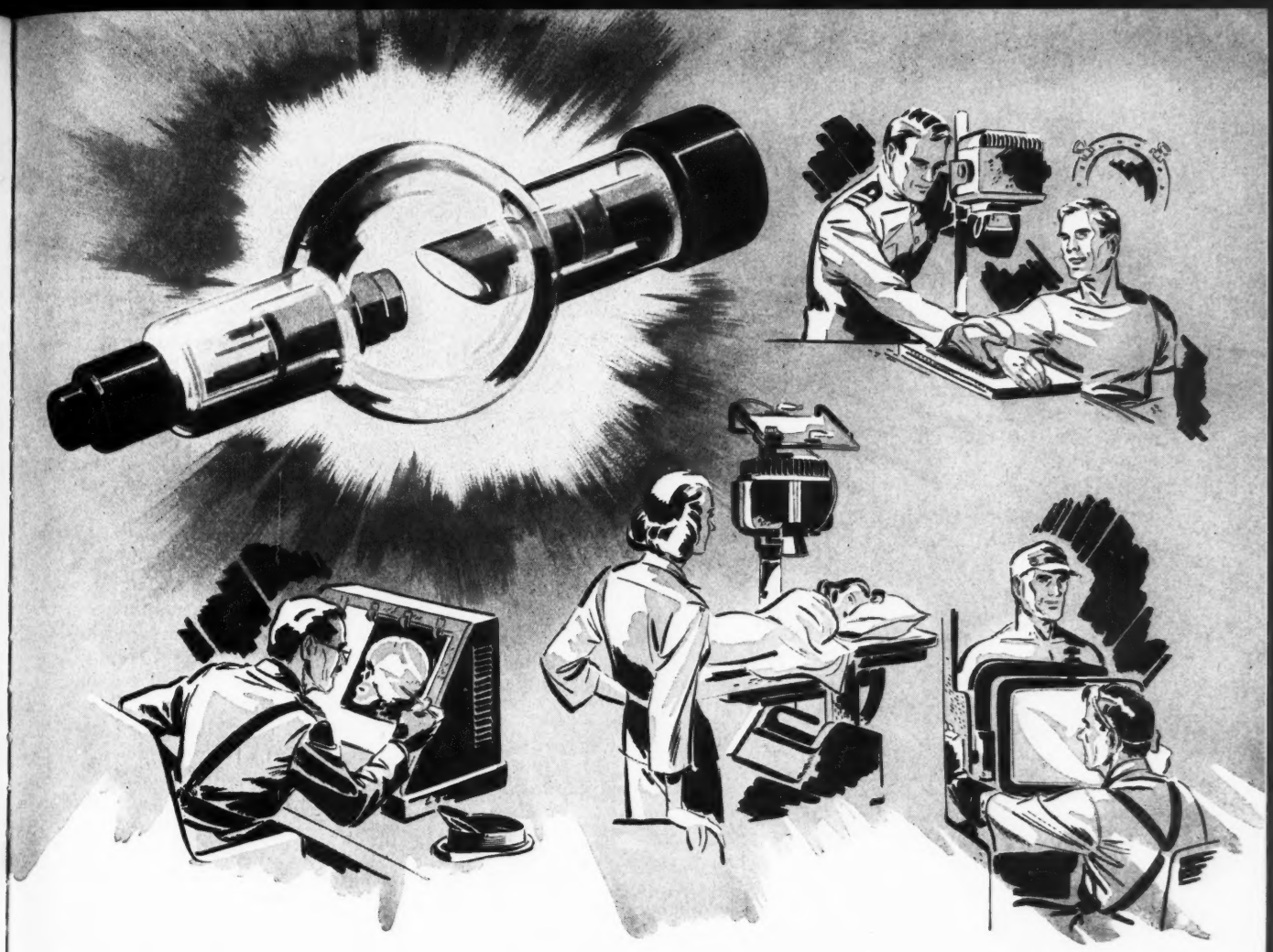
Last year's officers will carry on for another year: President, Sister M. Evangeline, Pembroke General Hospital; Secretary, Sister St. Albert, St. Michael's Hospital, Toronto.

Photograph by W. B. Burwell (patient).

Br-r-r-r! Cold, isn't it?

Sorry, this is just a "bon ami" touch left on the windows of a ward in the Toronto General Hospital to simulate frost. This easily-applied window frosting, as part of a Christmas decoration scheme last December, completely fooled a number of the patients.

How good it has been, at the end, after wretched years of foreboding, to live in this time, and to watch Britain and the British Empire decline to fall. —*Douglas Reed.*



BLASTING THE ENEMY *on all fronts!*

This message is for radiologists and technicians everywhere

There is no part in the United Nations' war effort which X-Rays do not serve. The Army and Navy on the fighting lines and in their preparation and expansion . . . Civilian programs of voluntary service and Defense. Industry in producing the materials and weapons of *Offense.*

The speed and vastness of this many sided job and the contribution of X-Rays to its success are a challenge to every man and woman in radiological work. You have risen to the occasion thus far . . . you will continue to be successful in meeting whatever problems lie ahead.

Your equipment is good and your hands are skilled. Above all, you have a tradition of service to humanity.

You do not need to be told what *your* part is—but we want to renew *our* pledge in this emergency . . . that Patterson Intensifying and Fluoroscopic Screens will be made to the same standards of excellence . . . that you can expect the same cooperation from our dealer sources . . . that our products will continue to meet your requirements unfailingly, wherever X-Ray Screens have a job to do.

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New Rulings by Control Boards

Manpower Conservation

THE Wartime Prices and Trade Board has issued a statement of policy regarding the curtailment of civilian trade and industry to conserve manpower and womanpower. A condensation of the statement of this Board, issued October 21st, is as follows:

"The policy of the Government regarding manpower is that the best use must be made of all men and women and that every able-bodied man must undertake some form of essential service in the Armed Forces, in war production or in a vital civilian activity.

"It is clear that our manpower situation is now such that any further expansions of our war effort must come through deliberate transfers from civilian occupations and activities. The Government has accordingly decided that non-essential civilian activities should be curtailed or eliminated. The Wartime Prices and Trade Board which exercises control over civilian trade and industry has been directed by the Government to put this policy into effect.

"It is the intention of all concerned in this programme to proceed with curtailments in an orderly and progressive manner, having due regard for the speed required by the war programme. It must be realized, however, that the needs of the Armed Forces and essential industry are urgent and that industry will have to embark on plans for reduced operations that will not have all the refinements that might be desired.

"The Board will proceed along the lines of the curtailment of goods and services; that is, by way of control of production, supply and distribution. The withdrawal or transfer of labour from one industry to another will be under the jurisdiction of the Director of National Selective Service.

"Each of the Administrators of the Wartime Prices and Trade Board has been asked to formulate definite plans and recommendations for curtailment of products and services within his jurisdiction. In doing so each Administrator will consult with Advisory Committees already appointed, and will encourage advice and suggestions from industry at large. This procedure will be followed to ensure that the Board is given the benefit of the practical experience of the industry. Furthermore the Director of National Selective Service will be kept posted on every specific curtailment programme affecting labour so that he may be in a position to consider and discuss plans with representatives of Labour.

"*First moves* in each Administration will be the elimination of the obviously non-essential lines and standardization and simplification of continuing lines.

"A sharp *curtailment* of total production will also be required and this raises the important and vexed question of *relative essentiality*. It is recognized that there is likely to be a wide divergence of view on this subject and, as this is the criterion upon which curtailment must be based, the Board and its Administrators are studying the matter from every possible angle, and searching every source for information upon which to form an intelligent judgment of the strictly essential requirements of the civilian population. Obviously, it is impossible to establish an essentiality rating list for industries as a whole. Obviously, there is a non-essential element or less-essential element in practically all types of industry.

"*Concentration* of industry will be required in some cases to release manpower and to ensure efficient production of minimum civilian requirements. In some cases it may be found advisable to close part of an industry and concentrate the remaining production in selected plants.

"An extension of consumer *rationing* is likely to be an inevitable consequence of curtailed production. With this in mind we are already organizing local rationing boards at strategic centres throughout Canada, to apply the principles and policy that will be decided in regard to specific commodities. We should like to emphasize that consumer rationing is essentially a plan to ensure equitable distribution of available supply rather than any attempt to enforce arbitrary deprivations."

Housing Restrictions

Hospitals employing personnel who live out will have a particular interest in Order No. 200 of the Wartime Prices and Trade Board dated 4th November, 1942, which sets aside local bylaws, restrictions, covenants and leases which would prevent the taking in of roomers or the sharing of housing accommodation with others.

This measure has been passed to help solve the problem created by the lack of housing accommodation in many areas wherein the population has become greatly increased during the war. Most of the larger communities and some of the smaller towns across Canada are included in the schedule. In the case of the cities mentioned, the abrogation of restrictions is applicable within a radius of 25 miles from the limits of any such city.

Rubber Cement not Available

Information has been received that supply houses are not accepting orders for rubber cement for the repair of gloves, etc., in accordance with a recent order permitting the sale of rubber cement for the repair of tire tubes only.

The Canadian Hospital Council has taken this matter up with the Rubber Controller and has pointed out that it is distinctly in the interests of rubber conservation to make rubber cement available for patching gloves. Further announcements will be made later.

Stop Press

As we go to press we are informed that the Rubber Control has agreed to correct this situation and is notifying supply houses accordingly.

Rubber Again

Hospitals are again reminded of the great urgency that every piece of rubber that has become worn out be returned as salvage. It is particularly important to save old gloves, medicine stoppers, tubing, sheeting, hot-water bottles, ice caps and rubber mats.

Keeping Drug Costs Down

THE Manitoba Hospital Service Association has issued a fine formulary prepared for them by the Manitoba Guild of Pharmacists in co-operation with a number of leading physicians.

The use of pharmacopoeial drugs is urged. In the foreword it is stated: "A cursory glance at the declared formula of many of the "specialties" reveals them to be loaded with substances long since proven therapeutically useless but still retained simply to give the formula an imposing appearance." Frequently, too, pharmacopoeial drugs or substances almost identical are used under trade names at increased cost. "The following simple comparison of price between certain pharmacopoeial drugs commonly used and the trade names of drugs believed to be identical or to have only slight differences, being used for similar treatments, may be of interest." The prices given are said to be accurate within a close margin in Manitoba, but may not be exactly the same for other parts of Canada. There may also be variation due to the war since the formulary was published this past summer.

Pharmacopoeial Drug	Drug under a Trade Name
Acid Acetylsalicylic B.P. C.T. 5 grains. 75c per 1000	*Acetophen*—5 grains. $1.50 per 1000 *Empirin*—5 grains. $5.00 per 1000
Barbitone Soluble B.P. C.T. 5 grains. $6.00 per 1000	*Medinal* C.T. 5 grains. $20.00 per 1000
Dibrom-oxymercuri-fluorescein Sodium 100 grammes $4.50	*Mercurochrome* 100 grammes $15.00
Chlorbutanol B.P. 1 ounce 40c	*Chloretone* 1 ounce 85c
Hexamine B.P. C.T. 7½ grains. $3.60 per 1000	*Urotropin* C.T. 7½ grains. $20.00 per 1000
Paraffin Liquid B.P. (Medium Weight) $1.15 per gallon in 45 gallon drums	*Nujol* 100 ounces $2.80 *Alboline* 16 ounces 75c
Paraffin Molle B.P. Yellow 12c per pound in 50 pounds	*Vaseline* Yellow 35c per pound
Paraffin Molle B.P. White 20c per pound in 50 pounds	*Vaseline* White 6c per pound
Phenobarbitone B.P. Tablets C.T. ½ grain. $1.35 per 1000 C.T. 1½ grain. $3.37 per 1000	*Luminal* Tablets C.T. ½ grain $12.48 per 1000 C.T. 1½ grain $26.08 per 1000
Phenobarbitone B.P. Tablets C.T. 1½ grain. $3.37 per 1000	*Gardenal* Tablets C.T. 1½ grain $25.00 per 1000
Phenobarbitone Sodium B.P. Powder $2.00 per 4 ounces	*Luminal Sodium* Powder $3.68 per 4 ounces
Procaine Hydrochloride B.P. $3.06 per 4 ounces $12.00 per 16 ounces	*Novocaine Hydrochloride* $10.52 per 4 ounces $29.60 per 16 ounces
Liquor Cresolis Saponatus B.P. $1.15 to $1.25 per gallon in 45 gallon lots	*Lysol* $1.25 per gallon in 45 gallon lots
F.E. Ergot B.P. 55c per 1 ounce	*Ergoklonin* 85c per 1 ounce

Proprietary Articles with Official Preparations of Analagous Effect

Agarol
$1.08 for 16 ounces

Analgesic Balm
$3.50 for 16 ounces

Alphamel Ointment
$1.60 for 16 ounces

Anusol Suppositories
90c for box of twelve

Argyrol
$1.00 for 1 ounce

Fellow's Syrup
$1.08 for 16 ounces

Glucophedrin
$6.00 for 16 ounces

Iodex
$5.00 for 16 ounces

Iodex c. Methyl Salicylate
$5.00 for 16 ounces

Loraga
90c for 16 ounces

Pulv. Cal-Bis-Ma
$1.89 for 16 ounces

Ozonol
95c for 16 ounces

Taroxide
No. 1. $1.75 for 16 ounces
No. 2. $2.65 for 16 ounces

Tar Alba
"B" $2.50 for 16 ounces

Theominal
50c for 12 capsules

Emulsion Paraffin Liquidi cum *Agar Compositae* B.P.C.
50c for 16 ounces

Unguentum Methyl Salicylate Comp. B.P.C. $1.20 for 16 ounces

Cod Liver Oil c. Honey Ointment
60c for 16 ounces

Suppositori Bismuth Comp. B.P.C.
40c for box of 12

Argentii Protein. Mite. B.P.C.
65c for 1 ounce

Syrup Hypophosphites Comp. B.P.
50c for 16 ounces

Dextri-Fedrin
$1.50 for 16 ounces

Stainless Iodine Ointment
75c for 16 ounces

Stainless Iodine Ointment c. Methyl Salicylate 80a for 16 ounces

Emulsion Paraffin Liquidi cum *Agar* B.P.C. 50c for 16 ounces

Pulv. Calcium & Bismuth
50c for 16 ounces

Thymol Iodide Ointment Comp.
50c for 16 ounces

Coal Tar Distillate Ointment
No. 1 or No. 2 $1.00 for 16 ounces

Coal Tar Distillate Ointment
No. 1. $1.00 for 16 ounces

Capsules Theobromine c. Phenobarbitone
25c for 12 capsules

Is Your Call Necessary?

In an effort to co-operate the Royal Victoria Hospital in Montreal has printed the following message on a card which is placed near telephones:

Is Your Call Necessary?

The President of the Bell Telephone Company makes the following appeal:

> "The use of the telephone for out calls should be confined to those that are absolutely necessary. Even essential calls should be as brief as possible. That is the only way the telephone service can meet the ever-growing requirements of a nation at war."

The Hospital Management concurs in this request and asks telephone users to voluntarily ration themselves NOW rather than wait for compulsion.

B. C. Hospitals Study Insurance Plan

The hospitals of Vancouver, North Vancouver and New Westminster are considering a plan of hospital insurance for the residents of the Lower Mainland. The study has been under way for some time, with particular attention being paid to the operation of plans in other parts of Canada and in the United States.

Final details of the plan will shortly be submitted to the boards of directors of the hospitals concerned. It is expected that the body chosen to carry out such a plan will be under the jurisdiction of the interested hospitals.

Once Upon a Time

THE variety of fare served in hospitals to-day is surprising. But about one hundred and seventy years ago, the following tables of diet were considered sufficient to whet the appetites of patients, and keep body and soul together.

A full diet consisted of:—

Sunday and Thursday

Breakfast: A pint of water gruel
Dinner: Half a pound of boiled beef with greens
Supper: A pint of broth

Monday

Breakfast: A pint of milk pottage
Dinner: A pint of rice milk.
Supper: Two ounces of cheese, or butter

Tuesday and Saturday

Breakfast: A pint of water gruel
Dinner: Half a pound of boiled mutton with greens
Supper: A pint of broth

Wednesday

Breakfast: A pint of milk pottage
Dinner: Half a pound of boiled pudding
Supper: A pint of water gruel

Friday

Breakfast: A pint of milk pottage
Dinner: A pint of plumb broth
Supper: Two ounces of cheese, or butter

The patients on this diet were allowed one loaf of bread per day. This weighed fourteen ounces. They were also allowed three pints of small beer per day from Lady-Day to Michaelmas, and one quart per day from Michaelmas to Lady-Day.

Those on a low diet were served with:

Sunday

Breakfast: A pint of water gruel
Dinner: Two ounces of roasted veal with a slice of bread pudding
Supper: A pint of broth

Monday

Breakfast: A pint of milk pottage
Dinner: A pint of rice milk
Supper: Two ounces of cheese, or butter

Tuesday and Saturday

Breakfast: A pint of water gruel
Dinner: Two ounces of boiled mutton with greens, and a pint of broth
Supper: A pint of broth

Wednesday

Breakfast: A pint of milk pottage
Dinner: A slice of boiled pudding
Supper: A pint of water gruel

Thursday

Breakfast: A pint of water gruel
Dinner: Two ounces of roasted veal, and a pint of milk
Supper: A pint of broth

Friday

Breakfast: A pint of milk pottage
Dinner: A pint of plumb broth
Supper: Two ounces of cheese, or butter

Patients on this diet were also allowed one loaf of bread per day. But only one quart of beer per day from Lady-Day to Michaelmas, and one pint per day from Michaelmas to Lady-Day.

The following was the menu for those prescribed a milk diet:

Sunday, Tuesday, Thursday and Saturday

Breakfast: A pint of milk pottage, or water gruel
Dinner: A pint of plumb pottage, and four ounces of bread pudding
Supper: A pint of milk pottage, or water gruel

Monday, Wednesday and Friday

Breakfast: A pint of milk pottage, or water gruel
Dinner: A pint of rice milk
Supper: A pint of milk pottage, or water gruel

These patients were allowed one loaf of bread per day, and three pints of drink, of which one pint had to be milk and two pints water.

Patients having a fish diet had fish for dinner on Mondays, Wednesdays and Fridays, "if it can conveniently be had; if not, the Low Diet."

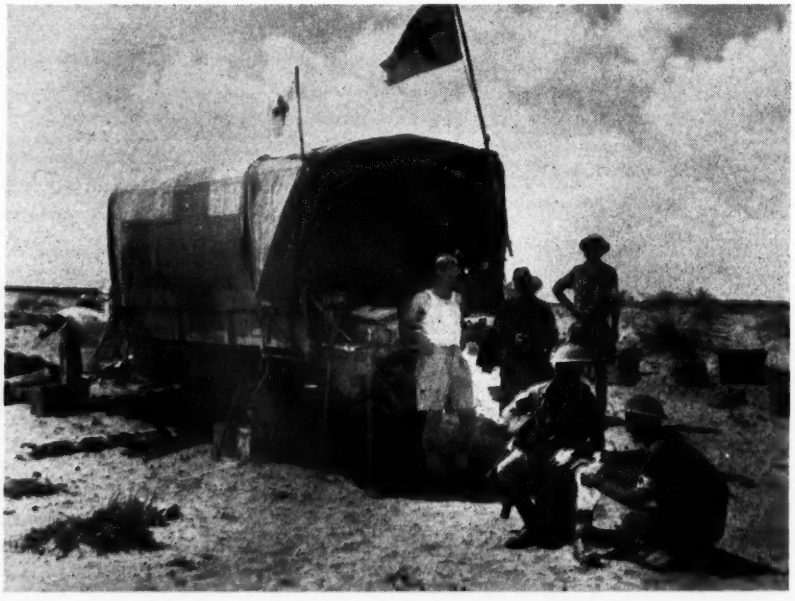
Patients on a dry diet had to have two ounces of butter or cheese for breakfast, and the same for supper, every day of the week, and a low diet for dinner but without broth or rice.

They were also allowed milk on Tuesdays, Thursdays and Saturdays and bread and beer as prescribed for the Low Diet.

Patients upon a raisin diet could have half a pound of raisins per day, as much bread as they could eat, a quart of Decoct. Guaic. Fort., and as much of the Decoct. Guaic. Tenue as they could drink.

Patients under salivation or those who had an unnatural flow of spittle, were allowed one quart of milk per day and half a pound of mutton, which had to be boiled for broth.

— From *Hospital and Nursing Home Management*, December, 1941.



(Courtesy Australian Department of Information)
A Red Cross outpost in the Libyan Desert.

● While Crane literature is primarily designed for industry, you will find it of definite value to your maintenance staff in diagnosing, operating on and curing your hospital's piping ills.

REPAIRS DONE IN TIME KEEP VALVES ON THE LINE

While the War is on...

Data on design, installation and maintenance, made quickly available to industry's men, is important — whether they are trainees, skilled workers, technicians or professional personnel. Crane publications listed below will be found helpful . . .

"FLOW OF FLUIDS
through Valves, Fittings and Pipe."

For professional and engineering personnel. Technical Paper No. M409, consisting of 94 pages with data, charts, tables, formulas and working equations.

"PIPING POINTERS"

Illustrated shop bulletins for practical piping men. Particularly useful for employee training in plant schools. "Do's and don'ts" of valve and pipe selection, installation and maintenance, in a form for wall posting.

CRANE GENERAL CATALOGUE

A practical guide to the selection of Valves, Fittings and Pipe for industry's widely varied requirements. Several sections are particularly useful to piping and hydraulic engineers, containing a broad range of engineering data and tables on piping systems, also technical information relating to Pipe and Pipe Threads, Pipe Bends and fabricated work.

Any of these publications are available to those interested, either from the address below or any Crane branch across Canada.

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1170 BEAVER HALL SQUARE · MONTREAL · CANADA
NATIONWIDE SERVICE THROUGH BRANCHES, WHOLESALERS, PLUMBING AND HEATING CONTRACTORS

Resolutions of Catholic Hospital Association

Health Insurance

As in previous years a feature of the Catholic Hospital Association meeting in June was the preparation and acceptance of a number of resolutions on a wide range of topics of interest to the hospital field. Among the fifty published in the October issue of *Hospital Progress* is the following resolution on national health insurance:

"Be It Further Resolved, That this association recommend to the Catholic hospitals of Canada the most careful and painstaking study of the proposals of the Advisory Committee of the Department of Pensions and National Health with reference to the National Health Insurance Programme. The Association is deeply concerned with the possibilities for good to be achieved through wise legislation as it is equally concerned with the possibilities for harm which may result from an inadequately considered programme. The issues involved in the National Health Insurance as now proposed are extremely far-reaching. They may, on the one hand, further the extension of Catholic hospital service, but on the other, they may equally destroy that which has been accomplished through three centuries of persistent and self-sacrificing striving. The Sisters of the Catholic hospitals of Canada should be encouraged to voice their own convictions with courage and decision and to express the results of their well considered judgment in the interest not only of the national welfare, but also in the interests of the Church and our Catholic institutions."

Hotel Dieu de Montreal

Another resolution was one of congratulation to the Hotel Dieu de Montreal on the celebration of its 300th anniversary:

"Be It Resolved, That the Catholic Hospital Association of the United States and Canada, at the close of its Twenty-seventh Annual Convention, express its deeply felt congratulations to the Sisters of the Hotel-Dieu de Montreal on the tercentenary of the organization of their hospital. Their tercentenary is our tercentenary, for it marks the appearance on the stage of North American history of the giant figure of Jeanne Mance whose enduring influence upon hospital and welfare work in the United States and Canada has persisted during these three centuries and is more alive to-day in the great work of the Religious Hospitallers of St. Joseph than it was in the days of her earthly ministrations. By uniting in an heroic degree the works of her pious and vigourous Faith with her self-sacrificing efforts for the poor and the suffering, she has set an example to every Catholic nurse, lay and Religious. Her glory in this tercentenary and the glory of the Religious Hospitallers of St. Joseph is the glory of every Catholic hospital Sister and every Catholic nurse. This Association acknowledges its debt of gratitude to the Religious Hospitallers of St. Joseph, its unbounded admiration for their spirit and their achievement, and offers in deep humility and appreciation this resolution as a taken of its sentiments to the Sisters of the Hotel-Dieu de Montreal. United as we are in a common Faith, in common ideals, in common activity in the following of Christ, we beg His Sacred Heart to grant to the Religious Hospitallers of St. Joseph the fullest measure of Grace in His abundant Charity."

Hospitals Decide to Ration Facilities for Maternity Care

"Rationing" of hospital service to maternity patients, so that the greatest number of mothers and their babies may enjoy the benefits of hospital attention, has been set up by the two large community hospitals in Bridgeport, Conn. We believe that similar arrangements have been made in California and elsewhere and it is possible that this procedure may become widely adopted in areas where hospital accommodation is at a premium.

Acting jointly, the two hospitals have agreed:

1. To reduce the average hospitalization of maternity patients to seven days after delivery of the baby. At the discretion of the attending physician, mothers will be hospitalized longer.

2. Patients will be asked to co-operate by lessening the number of demands upon the time of nurses, in instances where the service has no bearing upon the safety of the patient.

3. Relatives and friends of the patient are asked to reduce the demands upon hospital personnel, and reduce possible sources of danger to patients, by observing the following:

(a) Visiting hours for all patients—private, semi-private and wards—will be from 7 to 8 p.m.

(b) Any religious ceremony should be arranged for at the baby's home, on the eighth day after birth and after discharge from the hospital. In the event the ritual, for any reason, has to be performed in the hospital on the eighth day, the number of witnesses will be limited to three persons. (This minimum number of witnesses has the sanction of Rabbinical law.)

(c) A father will be shown his baby once before the child is prepared for his or her home-going.

4. Flowers will be received only in special containers which require no time for nurses for arrangement, watering and other attention. Local florists have agreed to co-operate in this matter, supplying chemically-treated paper containers in which flowers are already arranged and to which only water need be added.

5. The saving of the time of nurses, otherwise occupied with non-essential duties, will be employed to augment nursing service at night.

This maternity service code is based largely upon recommendations made by the Public Health Committee of the State Medical Association. It is considered that these new regulations will impinge little if at all upon the comfort of patients and not at all upon their safety; in fact their safety may be enhanced because of the reduced hazard of infection.

Many of our Canadian hospitals report that their obstetrical accommodation has been booked up for many months in advance, with many prospective mothers unable to obtain reservations.

Correspondence

Pupil Nurses not Dependants In Calculating Income Tax

The Secretary,
Canadian Hospital Council.

Dear Sir:

A rather fine point has arisen in connection with the persons who may be claimed as dependants by parents who are filling in Form TD1. Section (10) sub-section (2) lists dependants as "children, grandchildren, brothers or sisters under twenty-one years of age attending an educational institution." The question arises as to whether or not a school of nursing is an educational institution.

The parents contend that they are faced with expense of books, uniforms, spending money. They argue that nurses are required and that encouragement should be extended toward girls entering hospitals.

Yours sincerely,
R. Fraser Armstrong,
Kingston General Hospital

The Canadian Hospital Council took this matter up with the Commissioner of Income Tax, pointing out that the provision of room and board meets in part only the expenses of the nurse in training. Reference was made to the necessity for off-duty clothing, entertainment expenses, travelling allowance, hairdressing and other personal expenses. Many hospitals do pay a small honorarium monthly, but this is frequently required in large part for the purchase of uniforms, books, etc.

The Commissioner of Income Tax, Mr. C. F. Elliott, replies as follows:

"In reply to your letter of the 10th instant, this Department has given consideration as to whether or not a so-called training school for nurses qualifies as an educational institution within the meaning of that term as used in Section 7A of the Income War Tax Act. In the result, you are informed that the opinion is held that such institutions do not qualify as such inasmuch as they provide at least in part certain maintenance for such persons as may be in training. While no doubt the requirements vary with different training schools, it is not possible to make individual distinctions, and in effect we are not aware of any which would clearly qualify under the Act.

Yours faithfully,
(signed) *C. F. Elliott,*
Commissioner of Income Tax.

The era of general science and industrial development has brought about a society wherein people are now more dependent on one another and even on the State and where in many phases of life the social group is replacing the individual in significance. The new national and world philosophy, and a growing charitable and sympathetic instinct among men, impels them toward the day when none, great or humble, old or young, rich or poor, will fail in health for want of proper care.

Report of the Council on Administrative Practice, American Hospital Association.

Book Reviews

ADVANCES IN PAEDIATRICS, VOLUME I. Editor, Adolph G. DeSanctis, M.D., New York Post Graduate Medical School and Hospital; Associate Editors, L. Emmett Holt, Baltimore, the late A. Greene Mitchell, M.D., Cincinnati, Robert A. Strong, M.D., New Orleans and Frederick F. Tisdall, M.D., Toronto. Pp. 291, illust. Price $4.50. Interscience Publishers, Inc., New York. 1942.

This is a companion volume to *Advances in Internal Medicine* reviewed in October. There are eleven contributors to this work writing under the headings of Toxoplasmosis, Review of Virus Diseases, Chemotherapy in Diseases of Infancy and Childhood, Electroencephalography, Vitamin K in Haemmorhage of the Newborn, Persistent Ductus Arteriosus, the Premature Infant, Tuberculosis, Endocrinology and Abstracts of other Advances. It is proposed to issue this volume annually. In contrast to a common procedure, the authors have selected but a few topics and have developed them thoroughly. This volume can be recommended to paediatricians, to practitioners in general and for hospital libraries.

* * *

DOCTORS OF THE MIND, THE STORY OF PSYCHIATRY. By Marie Beynon Ray. Pp. 329, $3.75. McClelland and Stewart, Ltd., Toronto. 1942.

During the past few years the long-hidden dramatic aspects of medical progress have been revealed by a number of writers for the bookshelf and the screen. Some of these, such as de Kruif, have dipped lightly across the ages, others, such as Flexner, have cast the shadow of a biography across an intriguing generation. In this volume Mrs. Ray takes a subject that most medical students find about the dullest subject on the curriculum and makes it live as have few authors on psychiatry. She proves that the science of the mind, the painstaking gropings and triumphs of the great investigators and the conquest of many mental disorders constitute a story which is teeming with dramatic possibilities.

Though a lay journalist, Mrs. Ray has succeeded in obtaining a remarkable knowledge of this subject and has written for the general public a review of psychiatric progress which is based on fact, which will hold their attention to the last page and which cannot but be encouraging to all who appreciate how much is possible in this field. Though written primarily for the general public, it could well be read with great profit and enjoyment by both doctor and nurse.

* * *

HEALTH FOR THE YOUNG. By Lindsay W. Batten, M.B., M.R.C.P. Pp. 176. Price $2.00. George Allen and Unwin Ltd., London. 1942.

The author discusses the health of growing children, considering in turn environment, food, healthy living, disease, miscellaneous problems and sexual education. He does not deal specifically with topics under headings but rambles on in easy style developing his thesis from his own experience. His advice and comments would seem to be sound and are interspersed with much of his own philosophy of life. Written primarily for parents, it is not a home doctor book and answers few questions about disease. That is to its credit. However, on such a vital topic as nutrition the author is inclined to discount much of the recent advances in dietetic knowledge. Vitamins are barely mentioned and milk, as is common among British writers, is not appreciated. England's greatest eras were in periods of general malnutrition and the author even fears that a well-fed nation might become a nation of lotus-eaters. On the whole, however, it is a sensible book with a definite "he-man" approach.

Hospitals in Britain

(*Concluded from page 24*)

position. It is difficult to say that he is not the servant of the local authority though a decision has been given to that effect. The Court, however, skated over that point and left undecided the position of house physicians and surgeons. Time may show, perhaps, that the decision has raised as many questions as it has settled.

We can no longer undertake to provide every patient with "the best possible nursing care". What we shall undertake to do is to provide care which will be *adequate* for that case. —*Geo. Stephens, M.D.*

Matron-in-Chief Chosen as Canada's Outstanding Woman

Lieut.-Col. Elizabeth Smellie, matron-in-chief of the Nursing Service of the R.C.A.M.C., has been named the Dominion's most outstanding woman by a group of Canadian women editors.

Prior to becoming matron-in-chief, Lieut.-Col. Smellie was head of the Victorian Order of Nurses and has had a most distinguished career in nurse leadership. Last year she was First Vice-President of the Canadian Nurses Association.

15 Women Help Build Calgary Hospital

Workmen on the construction of the new Calgary military hospital include fifteen women. Among their jobs are operating hoists and toting wheel-barrows loaded with cement. The women assumed their jobs following a request by W. Harry Ross, supervisor of the Unemployment Insurance Commission.

Begin Work on Brooks Hospital

Construction has begun on the hospital for which the people of Brooks, Alberta, have campaigned so long. It will be a 16-bed building and will cost approximately $40,000.

Price Trends

(On basis 1926 = 100)

	Yearly Average 1941	Oct. 1941	Sept. 1942	Oct. 1942
Building and Construction Material	107.3	112.0	114.1	115.5
Consumers' Goods (Wholesale)	91.1	96.6	96.0	96.9
(On basis 1935-1939 = 100)				
Cost of Living	111.7	115.5	117.4	117.8

The Subsidiary Worker

(*Concluded from page* 18)

ways ready for nurse, washing dishes after giving nourishments, ushering visitors to patients' rooms, arranging flowers, answering call lights and many other minute tasks that infringe upon the nurses' time.

The apprentice in the course should be rotated in her work so that she will be prepared to give assistance when and where needed. After completion of her course, she could be placed permanently in one department. But it should be clearly understood that these non-professional workers must not transgress into the professional field. She should have a special uniform and should be taught that she is directly responsible to the professional nurse in all the services she performs.

A hospital operating without accurate and full financial analysis is like a ship sailing without a rudder. *W. H. Moffat, Saskatchewan Department of Health.*

The Hospital in War

(*Concluded from page 13*)

civilian hospitals keep thoroughly informed of developments in military medicine and adopt in their own institutions those which have proved efficacious. Should the time come when bombs fall on America, our hospitals will then be prepared to care properly for head injuries, fractures, shock, flesh wounds, burns and the like, resulting from enemy action. There is also increased knowledge of chemotherapy and of the use of blood and plasma—all of which assures better care of the soldier wounded in action and better preparedness at home in case of need. Supplementary to the regular medical staff conferences in hospitals these days, should be special sessions devoted to the study of the treatment of war wounds and the diseases that may increase in wartime. The British and Australian medical journals afford especially good material for such study.

This brings us to our final act, in which the threads of the entire plot are gathered into the climax showing the hospital ready for the vital work of rehabilitation and reconstruction that will follow the war.

Act X. The Hospital in Rehabilitation and Reconstruction

The attitude towards the hospital in post-war days is being shaped now. The importance of the part it plays *then* will be governed by the success with which it performs its war duties *now*. Materials and processes are being developed during the war which will mean wonderful improvements in our hospital plants and equipment when we can turn them to peacetime uses. The increased appreciation of the value of health now being aroused can be capitalized to good advantage when we embark on the great era of post-war progress. Worldwide rehabilitation of health will be vitally needed after the strains and horrors of the war. Educational programmes will have to be resumed on an enlarged scale to make up for the years in which so many of our young men and women have had to give up study for practical work.

Hospital workers are inspired by the knowledge that their aims can be realized only in a world in which cruel aggression is vanquished. Through their devotion to duty now, both on the fighting front and at home, the war effort is being furthered. They are staging a wonderful drama, and the spectators are thrilled by the life-saving feats that they witness. Night and day the play goes on, for the work of mercy must not lag, and the curtain must never go down.

Length of Hospitalization Decreasing in Saskatchewan

The average length of stay in hospitals is steadily falling, as calculated from a series of figures presented to the Saskatchewan Hospital Association by Dr. J. W. Lord, Provincial Medical Officer.

Year	*Patients*	*Days*	*Stay*
1929	60707	797587	13.1
1935	64278	778022	12.1
1941	88558	911341	10.3

No hospital can afford to be without a women's auxiliary. *Mrs. S. R. Curtain, Regina.*

The "Swap Column"

Have you anything that you would like to swap for something else? In these days when equipment is hard to obtain, it may just be that you have something for which you have no further use and which may be of value to another hospital which could dispose of equipment of value to you. On the suggestion of several people, *The Canadian Hospital* in this issue has set up a "swap column".

There will be no charge for the inclusion of any items in this column and it will be maintained as long as it serves any useful purpose to the hospital field. Both hospitals and supply houses are invited to send in offers and requests.

Name and address of hospital or advertiser must be given. Copy should reach the business office of the Canadian Hospital, 57 Bloor St. West, Toronto, not later than the 25th of the month for the following month's issue.

Surgical Instruments for Sale, some practically new, including: 73 pairs Haemostats or artery forceps, standard types. 49 only, Bone instruments — including drills, trephines, elevators, curette gouges, chisels, cutting and holding forceps, etc. 31 only, Bone plates (Vanadium steel). 1 only, Sharp and Smith large bone drill with burrs and drills. 67 only, Gynecological instruments — including senacular and vallcella forceps, cerineum needles, spacular, Goodall Dilator, curettes, scissors. 1 only, Set Hegars. Hollow uterine dilator in metal case. 28 only, Urethral instruments:— including catheters, sounds, dilators, catheter holders, crystoscope, urethescope stone searcher, urethotome. 15 only, Nasal instruments—specular, dressing forceps, catheters, saws, snare, belocynes, canular. 25 only, Stomach, intertinal; Hysterectomy clamps (standard patterns). 8 only, Dressing and tissue forceps—short patterns. 7 only, Abdominal wound retractors—various types. 1 only, Balfour abdominal retractor. 1 only Welch Allyn opthalmascope—large handle (may have to be adjusted).

Many other items available. Complete list on application. St. John's Convalescent Hospital, Newtonbrook, Ont.

* * *

1 small size Incinerator used only three times. 1 Rudd Heater which is in good condition. Daughters of the Empire Hospital for Convalescent Children, 54 Sheldrake Blvd., Toronto.

* * *

1 unused physician's register, 22½" x 50½", 54 name spaces, non illuminated, oak finish. The Public General Hospital, Chatham, Ont.

* * *

4 doz. New Wh.E. douche pans, similar to No. J/1012 (Hartz) at $18.00 a dozen, or would exchange for Wh. E. Perfection type Bed Pans. Royal Victoria Hospital, Montreal, Que.

* * *

1 McKesson Metabolor on portable stand, approximately 12 years old, needs repair to clock mechanism. The Nicholls Hospital, Peterborough, Ont.

WANTED: Experienced Dietitian-Housekeeper for fifty bed hospital in Central Ontario. Must be qualified dietitian. Apply at your nearest Employment and Selective Service Office, stating experience, age and salary expected.

HOSPITAL SUPERINTENDENT WANTED

(Graduate Nurse)

For 72 bed Hospital with Training School. Apply stating age, qualifications, experience, salary expected and when duties could be assumed to The Secretary, Board of Commissioners, Highland View Hospital, Amherst, N.S.

Better X-ray Diagnosis

(*Concluded from page* 15)

not used, will absorb oxygen and become useless in a few days. Let me stress the false economy of overworking the solutions used to process radiographs. The continued use of old, dark brown developer can only result in stained, hazy, foggy-appearing radiographs. The next time that your technician asks for a can of developing powder, don't let your remarks about cost be too cutting. Remember that the money lost by spoiling one 14 x 17 film through old oxidized developer will pay for the chemicals needed to make up a new gallon bath.

Selection of a Suitable Technician

Good radiographs, no matter what the size or cost of the X-ray machine, cannot be entirely the result of the automatic setting of certain controls. There is an over-present human element to be considered.

It is difficult for the technician in a small hospital to become really expert. Where there is very little work to be done, it is impossible to get proper experience, and if there are only a few cases per week, one cannot work up a great deal of enthusiasm. Very often the X-ray work is done by the matron, or a nurse, or a stenographer, or anyone who happens to be around. First-class X-ray work cannot be done under such conditions. These people are trained in their own field but usually they are not trained as X-ray technicians.

The diagnostic value of the finished film is surely the yardstick by which you measure the usefulness of the X-ray department. When the size of your hospital and the work you plan to do seems to warrant the installation of X-ray equipment, you should employ a technician who has been properly trained. The question of the *qualifications* of the technician is becoming more and more important as the extent and complexity of X-ray work increases. Especially is this true in the smaller hospitals, where the entire responsibility of positioning the patient, selecting a technique. etc., rests on the technician because of the fact that there may be no resident radiologist to direct procedures.

Since in X-ray work so much depends upon the proper handling of sick people, it is reasonable to suppose that nurses would make good technicians, and it often works out that way. It is obvious that they have already had much of the professional attitude and responsibilities taught to them. They understand the relationship between physician and patient, although this does not imply that these attributes cannot be acquired by others.

It has become a common practice —which is working very well in many small hospitals—to have one person do both laboratory and X-ray work. The University of Saskatchewan now provides a course leading to a degree, a course which is planned to give the students fundamental training in both laboratory and X-ray

work. This is concrete evidence of the need for trained technicians of that type; graduates from these courses should make excellent technicians.

It is highly desirable that there be evolved some plan whereby the services of the senior technicians in the province and the facilities of the X-ray departments of the larger hospitals could be made available to the technicians of the small hospitals. It might be better yet if arrangements could be made for senior technicians from larger hospitals to spend a few days in the smaller hospitals where, realizing local conditions, they would be in a better position to offer advice.

In addition to this, the technicians should be encouraged to keep up with and become proficient in the latest technical developments, and where possible provision should be made for their attendance at meetings of fellow technicians where, by consultation with those doing the same work, much of value may be learned.

Conclusion

Although it is true that the service rendered to a community by the X-ray department of a hospital cannot be fully measured in terms of dollars and cents, there will be some among you holding positions which force you to consider costs and revenue. It is part of your work to make the X-ray department self-supporting. It must be evident to you that as the diagnostic quality of the films produced in your X-ray department improves, the demand for that service will increase and revenue will follow.

On the other hand, films which are poor or are so imperfect that they cannot be interpreted are not only a waste of time and money but—of more importance—they fail to assist the physician to make a correct diagnosis. What is more they often necessitate further expenditure to the patient before the diagnosis is made. Such work discourages the local use of what could be a very valuable asset to your hospital, your community.

Toronto East General Builds

Ground has been broken for the new $500,000 wing at the East General Hospital, Toronto. It will be five and a half storeys high and will contain 158 beds and 50 cots.

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DECEMBER, 1942

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